EFFECTS OF BUDGET CONSTRAINTS ON QUALITY AND QUANTITY OF HEALTH CARE SERVICES

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

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EFFECTS OF BUDGET CONSTRAINTS ON QUALITY AND QUANTITY OF HEALTH CARE SERVICES

Monday, May 15, 1989

House of Representatives,
Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs,
West Haven, CT

The subcommittee met in Building 2, VA Medical Center, West Haven, Connecticut, Hon. Bruce Morrison, presiding.

Present: Representatives Morrison and Rowland of Connecticut.

OPENING STATEMENT OF HON. BRUCE A. MORRISON

Mr. **Morrison**. I want to call to order this field hearing of the Subcommittee on Hospitals and Health Care of the Veterans' Affairs Committee of the House of Representatives.

I'm very pleased to have this opportunity to have this subcommittee here in Connecticut. I'm very thankful to our full committee and subcommittee chairman, Sonny Montgomery, Congressman from Mississippi, longtime leader in the House of Representatives on behalf of veterans, who has authorized this field hearing for the purpose of collecting testimony and hearing from leaders of the Veterans' Administration here in Connecticut, and hearing from those who work on behalf of veterans, and those who are the advocates for veterans, and veterans themselves through the service organizations.

We have a very ambitious agenda for today. We got lots of advice in putting this hearing together to cut things out, but we've tried very hard to keep things in, in order to see to it that the subcommittee gets the maximum possible exposure to concerns of people here in Connecticut, and here at West Haven in particular. And therefore, I will need your indulgence and your assistance in getting through what is a very long agenda in a relatively short period of time. We have from now until approximately 6 o'clock, and we have a very tight schedule. So this gavel may have to be used.

Our witnesses are going to be asked to be brief, and Mr. Rowland and I will try to be brief in questions that we ask. We want you to focus for us, all who are witnesses, on the most important points that you have to make.

As you know, I am available, Mr. Rowland is available at other times, as well, for more expansive discussion of these issues. This is making a formal record for the benefit of the Veterans' Affairs

Committee to highlight those issues that we need to focus on in Washington.

The bottom line is that we have a system with many obligations. A Veterans' Administration health care system with many, many veterans with needs to be met. And we have to find out the best way to do that and where the problems are in the system. And the way in which we need to respond in Washington most effectively.

There is a commitment on this subcommittee to respond to the needs of veterans. And it has been my pleasure, since joining the Veterans' Affairs Committee for the first time in this Congress, to find in its staff and in its membership a real, solid commitment to needs of veterans. So you're talking to an organization, in terms of the Congress, that's committed to trying to do all that it can to respond. So we'll be welcoming your testimony in that regard, and we thank you all for coming, those of you who are going to testify, those of you who are here to listen. And I'd like to now invite the gentleman from Connecticut, Mr. Rowland, to give whatever opening statement he'd like.

OPENING STATEMENT OF HON. JOHN G. ROWLAND

Mr. ROWLAND. Thanks, Bruce. First a special welcome to all, especially our panelists and those that will be testifying and representing veterans organizations. I also want to thank Norm Browne and his excellent staff for hosting this very important hearing this afternoon.

Since the beginning of my tenure in Congress, I have had the privilege to serve on this committee. I am honored that Sonny Montgomery, the chairman of the subcommittee, who has been here, chose to hold a field hearing here today.

I believe that now is an appropriate time to focus on the effects of budget restraints and the quality of veterans health care here in Connecticut.

Across the country, veterans health care programs have been terminated. Hospital beds are being taken out of service, and veterans have been denied the medical care to which they are entitled. It is my pleasure to have this opportunity to be part of this hearing and concentrate on issues such as the recruitment and retention of health care professionals, the Department of Veterans Affairs budget, the modernization of Newington and West Haven medical facilities, and programs for homeless vets.

Over the past 10 years, the Department of Veterans Affairs medical budget has remained level, while the number of inpatients treated has increased by 7 percent, the number of outpatients has increased by 29 percent, and nursing home admissions have increased by 63 percent. During the same time, competition for health professionals has reached new heights. The veterans health care system finds itself needing to pay more in order to recruit many specialists, especially nurses, as well as physical therapists and pharmacists.

In response to a recommendation of the Veterans' Affairs Committee to increase funding for DVA programs, the House of Representatives approved an amendment to the recently passed budget. The amendment provided an increase of $395 million for next year's budget for the Department of Veterans Affairs. This funding is also $900 million higher than the level proposed by the administration. Most of the additional funding is targeted for veterans medical care. While the House budget resolution would allow up to $11.6 billion for veterans medical care, additional action is needed to restore veterans' health care to adequate levels. Therefore, our committee has recommended a $432 million supplemental appropriation for the current fiscal year. It looks as though we're going to get approximately $340 million.

As a result of the current budget crisis, we have to consider other actions. In this regard, I would like to commend the efforts underway in Connecticut by the two Department of Veterans Affairs hospital directors. The directors have been working together to create a new, innovative plan under which each facility would have more clearly defined roles in providing specialized treatment for veterans. By joining together and reinforcing each other, they can obtain productivity and provide more comprehensive services to veterans than would be possible separately.

I look forward to receiving testimony from those individuals involved and look to new ideas and ways to improve veterans health care services to Connecticut. Together, we can work to find ways to provide quality medical care at both of our facilities.

Mr. Chairman, with that objective, I would also request that the hearing record remain open for the next 5 days for the inclusion of any additional statements.

Mr. MORRISON. Without objection, so ordered. I would note for the record that a representative of Congressman Christopher Shay's office in Connecticut is here to listen to this testimony on behalf of the Congressman as well.

We'd like to call our first panel. Please come forward and take your seats. Mr. Albert B. Washko, Director of the Northeastern Region of Veterans Health Services and Research Administration of the Department of Veterans Affairs; Mr. Norman E. Browne, Director of the Medical Center here at West Haven; Mr. Robert K. Davenport, Director of the Medical Center at Newington, Connecticut; and Mr. Thomas Brownell, Director of the Veterans Benefits Administration Regional Office in Hartford, Connecticut.

I'd like to thank all four of you for making yourselves available to the subcommittee today. We look forward to your testimony. As I said earlier, we'd like you to summarize your testimony, hit the high points, let us know what we should be most concerned about. Your entire written statement will be made part of the record of this hearing.

Mr. Washko, if you would proceed first, thank you.

STATEMENT OF ALBERT B. WASHKO, DIRECTOR, NORTHEASTERN REGION VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Mr. WASHKO. Thank you, Mr. Morrison, thank you, Mr. Rowland. I've had the opportunity to work with both of you gentlemen over the past 2 or 3 years for improving the financial condition and improving the lot of veterans in Connecticut. And it's been a real pleasure. You two, indeed, are veterans' advocates. I see that in action.

The major issues that are facing the Department of Veterans Affairs boils down largely to finances. Dr. Gronvall, when he testified before the Senate Veterans' Affairs Committee last summer and before the House Veterans' Affairs Committee last summer, made the point that the VA has received over the last decade 20 percent less money than the private sector has through Medicare and through the Department of Defense health care funding. In other words, veterans health care funds has remained relatively flat over the last 10 years, after you take into account inflation.

On the other hand, Medicare funds, Department of Defense health care funds, have increased approximately 20 percent after inflation. Now, it's very hard for the Department of Veterans Affairs to deliver the same kind of care with 20 percent less budget, and therein lies our problem. We are held to the same expectations that our private sector brothers and sisters are meeting with 20 percent less budget.

The second part of our dilemma has to do with our competitiveness to recruit our employees and retain our employees. Paul Volcker, as you know, has recently chaired a very prestigious commission on the public service that has even contained a couple of ex-presidents, some major chief executive officers of private corporations, and that committee in its report has pointed out that the Federal service is becoming increasingly less competitive. And as a matter of fact, its salaries are in the magnitude of one-quarter below the private sector rates. This is giving us very major problems. There are some occupations that were considerably more than 25 percent less than competitive.

The third area that I would bring to your attention is capital facilities funding. The 23 hospitals in the northeast region have major facility needs. This facility is one. About one-half of the 23 facilities that I am responsible for have had no major clinical addition, no major expenditures put into their physical plant, despite the fact that some of them are 40, 50, 60 years old.

So in summary, we have a need for operating funds. We have a need for the Federal wage system to be revitalized so that we can be competitive for the employees that we need to take care of our veterans. And thirdly, we need a major infusion for our facilities to bring them up to date.

Thank you for this opportunity to speak to you.

[The prepared statement of Mr. Washko appears on p. 66.]

Mr. MORRISON. Thank you again, Mr. Washko.

Mr. Browne.

STATEMENT OF NORMAN E. BROWNE, DIRECTOR, DVA MEDICAL CENTER, WEST HAVEN, CT

Mr. BROWNE. Thank you, Mr. Morrison, and thank you, Mr. Rowland.

My testimony today focuses on what Mr. Washko just mentioned as one of his three major issues: that Federal employment is becoming increasingly less competitive. In my written testimony, I have provided several examples. Let me read just one.

We have a 25-year-old worn out air conditioning system in this hospital. And this afternoon, some of us may get a chance to experience how that feels. To maintain that, we have four positions allocated to air conditioning mechanic. At this instant, three of those four positions are vacant, and the one remaining mechanic is seriously considering a non-Federal position that pays about 180 percent of what he makes with the VA.

These other examples also show that we have a serious problem in terms of recruitment. We have entire sections of the hospital with 200 to 300 percent turnover rates. That means that our entire staff in some sections quits every 4 months.

High quality medical care requires that nurses be able to get the clerical support that they need, that doctors be able to find medical records, that patients who need to be taken to the operating room can get an elevator. And these parts of our system are not working well. We're thankful for the help that special salary rates have provided, but they do not solve the problem. And in addition to that, they create anger and frustration in employees who do not get the special rates, and in managers, for instance, who supervise employees who make more than the managers do.

I very much appreciate both of your interest in the institution and thank you.

[The prepared statement of Mr. Browne appears on p. 78.]

Mr. MORRISON. Thank you very much, Mr. Browne.

Mr. Davenport.

STATEMENT OF ROBERT K. DAVENPORT, DIRECTOR, DVA MEDICAL CENTER, NEWINGTON, CT

Mr. DAVENPORT. Thank you, Congressman Morrison and Congressman Rowland. It is an extreme pleasure to be with you today.

I will deal more with the Newington VA and the changes that are going on there. At the beginning of this fiscal year, Newington was facing a $1.2 million budget deficit. Although this was somewhat budget driven, a major portion of that was due to a declining work load at Newington. Our surgical work load at Newington had decreased 48 percent in 3 years, and we had not addressed that budgetarily. I think the important aspect of that is that this gave us an opportunity to look at what we were doing at Newington and to collaborate with the director and the staff at West Haven and develop what we have termed the Integrated Health Care Plan for Veterans for the State of Connecticut.

The cornerstone of this plan was to provide top quality cost effective health care to our current aging veteran population within available resources.

As an example, in Newington we had 51 discharges in ophthalmology surgery, 60 in ENT, 104 in urology. It became questionable whether with that number of caseload, we could maintain high quality medical care. As you know, there are set limits—numbers that should be performed for high quality care.

The integrated health care plan that we have developed and proposed is for all acute surgical and acute psychiatric inpatient care to be provided here at West Haven. Newington will still maintain all their ambulatory care programs to include surgery and psychiatry, and we will have all the acute medical programs. But we will expand into the area of long-term care and geriatric rehabilitation, which services are not currently available to the veterans of Connecticut.

Just recently, and I'm saying within the last 2 weeks, we have signed an agreement with Dr. Vestein, the Director of the Traveller Center on Aging. July 1, he will take over responsibility for staffing and developing our geriatric rehabilitation program. We are very excited about that.

So although this matter was budget driven, I think it gave us the opportunity to truly look at the health care for the veterans in Connecticut and provide higher quality care. And also expand the services to the veterans of Connecticut by moving Newington—at least 50 percent of the Newington Hospital in the long-term care and geriatric rehabilitation for both medical, surgical, and psychiatric patients, to include the Alzheimer's patients.

I also would just like to mention on pay. In order for any VA medical center to survive, we must be able to recruit high quality employees. The VA Central Office has been very gracious in approving special salary rates for the clinical side of the house: nurses, physical therapists, many of the other areas. In fact, at Newington, 68 percent of all employees at Newington are on special salary rate. Unfortunately, that does not include managers and/or supervisory personnel. Today, right now today, a staff nurse comes to work at Newington at $6,000 more per year than a service chief makes. That's the highest level management official in a service, such as the personnel officer, the fiscal officer, supply officer. Consequently, we are losing many of our key administrative people who support the delivery of health care, and which will have a tremendous impact on the health care.

Mr. Brownell will mention and talk about the co-location of the regional office. I only want to say that we fully support that. We have designated space for that, and we are in full agreement with the co-location of the regional office at the medical center.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Davenport appears on p. 79.]

Mr. **Morrison**. Mr. Davenport, thank you very much.

Mr. Brownell.

STATEMENT OF THOMAS BROWNELL, DIRECTOR, VETERANS BENEFITS ADMINISTRATION REGIONAL OFFICE, HARTFORD, CT

Mr. **Brownell**. Mr. Chairman, members of the subcommittee, I'd like to take this opportunity to address the members of the House Veterans' Affairs Committee on behalf of the Department of Veterans Affairs Hartford Regional Office. We are most appreciative of your interest in veterans interests in this State and how we may best serve them.

One of our major concerns in this area is the issue of co-location, as Mr. Davenport has mentioned. We wish to acknowledge the House Veterans' Affairs Committee for their efforts to include our office in the fiscal year 1990 budget proposal for the co-location initiative. Although severe budget constraints had eliminated the project from the fiscal year 1990 schedule, the Department will introduce the project into the fiscal year 1991 budget submission. We eagerly await the opportunity to co-locate at the Newington Medical Center grounds.

From a mission standpoint, I believe that our clients will be best served if both the regional office and the medical center were co-located. Veterans would receive one stop service. Not only could they be treated for their medical problems, they could file the necessary benefit applications or review their claims. The new facility at Newington would also serve as an ideal location for the proposed consolidation of all New England loan guarantee activities. Co-existing on the same grounds would facilitate the coordination in obtaining medical evidence, eligibility, scheduling, verification, supplies, and counseling. Our adjudication and vocational rehabilitation staff could coordinate more effectively and efficiently with allied medical staff on both inpatient and outpatient veterans, providing a more unified approach to obtaining necessary medical evidence in rehabilitation.

The Hartford Regional Office is currently located in a GSA courthouse building at 450 Main Street in the city of Hartford. We presently pay GSA $20.35 per square foot, approximately $750,000 per year, in this location. Further plans call for additional renovations of this building to provide sufficient space for the Federal courts. GSA has indicated that they can readily backfill any space we currently occupy once we vacate to a new location.

Private parking lots that are available in the general area cost from $70 to $85 per month. Private industry in the city routinely provides parking to their own employees as a fringe benefit, or subsidize their parking in private lots. Our inability to provide similar incentives precipitated critical clerical losses. Handicapped parking is limited to the point of being almost non-existent. Problems associated with inaccessibility would disappear with co-location.

We contend that the current location in the city of Hartford, along with the current local business environment, has adversely affected our ability to attract and retain quality personnel. We suffered a 33 percent turnover rate during calendar year 1988. This high turnover has contributed to the lost time to production inherent in training new employees. Generally when new employees are recruited, they have tended to be less talented than those hired just 2 or 3 years ago, requiring more intensive training for longer periods of time.

One of the ways we have attempted to deal with decreasing staffing while providing our full array of services is through organizational consolidation. By consolidating our former administrative and finance divisions into one support service division and reorganizing our veterans services division to eliminate a supervisory position, we have reduced administrative overhead. This strategy is consistent with the Chief Benefits Director's goals of improved productivity and service to the veteran.

Federal recruitment problems are commonplace throughout the Nation, but are especially acute in this part of the country. In order to combat high turnover and improve recruitment, we functioned as the lead agency to spearhead a consolidated special pay request for all clerical GS-1 through GS-6 Federal employees in the State of Connecticut. Our efforts led to OPM's granting of special salary rates, approximately 10 percent higher than the current GS rates. Unfortunately, these rates are still not competitive when compared to current private industry and State and local government sectors. Preliminary data indicates that this year's consolidated rate request will be in the range of 15 to 17 percent and will include GS-7s and GS-8s in an attempt to narrow the pay gap.

Despite the high staffing turnovers, training strains, and relatively inexperienced work force required to learn sophisticated equipment, procedures and regulations, we have been able to improve timeliness of benefits delivery and associated services. The pending workload 1 year ago at this time was running close to 7 days. Our current pending workload is a little over 2½ days. We have been able to improve the productivity levels in each direct labor activity over last year's levels. Overall, station productivity is up 35 percent over last year.

We rely ever more increasingly on office automation technology to accomplish our mission with less employees. While we embrace this philosophy, we recognize the need for a fully trained, competent, experienced work force to operate and maintain this equipment.

In summary, it is our opinion that one of the ways to attract and retain competent personnel is to locate in an affordable area convenient to both the work force and the public they serve. Co-location provides an answer to all of these concerns. It provides a central location for veterans and their dependents to obtain both medical and benefit services, saving both time and money.

Thank you very much.

[The prepared statement of Mr. Brownell appears on p. 82.]

Mr. MORRISON. Mr. Brownell, thank you very much. First let me just note on the subject that you mentioned, that the major construction authorization legislation which has been reported by the Committee has included for fiscal 1990 the co-location project.

Obviously there's another step to this, which is passing it through the Congress and then getting the actual dollars appropriated. But at least on the authorization level, we're trying to be of some assistance to the long-term cost savings and efficiencies that that would provide.

Mr. Washko, I'd like to ask you about a couple of pending proposals that relate to the West Haven facility. First, that there has been a proposal for a major addressing of a problem of rusting windows and structural problems with respect to the walls here, apparently owing to some less than first class construction or engineering decisions made when this facility was built that raise the specter that not only the windows may be rusty, but the walls may be shaky. I wonder whether you could tell us the progress, the status of the proposal to remedy that problem with a major repair effort.

Mr. WASHKO. We're trying to aggressively address that. I gave the hospital here some funding to do architect engineering work. That was out of those funds that we were able to scrape up from some savings in other places in our operation. They used those funds very wisely, have come up with a plan. And the plan is in the Central Office for funding. We are pursuing that aggressively. We're going to gather as much funds for that as we can. I hope that we'll have some decisions in the next few months on the size of the funding for that.

There's no question that some of it will be funded. We're trying to pursue as much of the funding as we can at one time.

Mr. **Morrison**. This has your support? You think it's appropriate?

Mr. **Washko**. Absolutely.

Mr. **Morrison**. Along that same line, there is a question of clinical addition here at West Haven, most particularly the operating rooms, which here are inadequate and interfere with giving the best quality of care. We're asking the health care staff to work under really adverse conditions. It's interfered with the ability to keep the operating rooms open. And the very fine cardiac surgery program here has at various times been jeopardized by that.

I understand that there is in the pipeline a clinical addition. Could you tell us what the status of that is, and what we can do to help?

Mr. **Washko**. That's in the early stages of planning. We need to focus our attention on planning that, designing that. And once we have an optimum plan and design, then we'll need to focus our attentions on getting it funded. But we are in the very preliminary phases of focusing on the exact extent of the needs for that clinical addition.

Mr. **Morrison**. Some people have suggested there was a worry that because this has been somewhat long in coming, that we'd go back to square one and start over, but this is going to continue along the planning that's already been done, some preliminary architectural work and the like. Is that going to continue? We're not going to start this over as a new project?

Mr. **Washko**. Absolutely. We want to continue this and keep it rolling. The West Haven VA Medical Center is one of my highest priorities in the region. I want to see that we bring these facilities that have been neglected for some time along as quickly as possible, so that they can serve the veterans of Connecticut, particularly in light of this fairly innovative partnership we have between the Newington hospital and the West Haven hospital. I want to do everything I can to make that a model for what the VA might be in other parts of my region, or in other parts of the country.

Mr. **Morrison**. Thank you. Mr. Browne, you talked about the problem of recruitment and retention. And you and I have talked about that frequently. I'd just like to hear your reaction to what seems to be a growing interest in Washington to a regional pay system for Federal employees, generally. Do you feel that that would help to address the problems that you're facing in the pay area?

Mr. **Browne**. Yes, sir. I think that the primary solution that I see possible to address this. This is not a problem which is going to go away without some solution like that. For instance, since 1983, we've had five chief nurses. We've had our fiscal officer position stay vacant for 1 year. Our assistant chief fiscal position stayed vacant for 1 year. And a locality based pay system like you're mentioning, I think, is the solution.

Mr. **Morrison**. On another subject that is somewhat different but in some ways similar, recently this medical center has begun to have to turn down certain patients for treatment because they fell in so-called Category B and C as far as their income level and the type of care that they were seeking.

Do you have any suggestions to us as to whether people who are being turned down here are, in fact, in need in terms of medical indigency and the like, and need more? That we may be turning down people that we ought not to turn down?

Mr. **Browne**. Mr. Morrison, the concept of Category A, B, C, was the means test, which was designed to select out our highest and less high priority patients for care. I have no moral objection to attempting to do that. Our highest priority for care is the service-connected and the indigent. I agree with that.

The problem which you've just mentioned is the same as the Federal salary system. The cutoff roughly between Category A and Category B is $16,500 a year income if you're not service-connected. $16,500 a year in the Deep South in Mississippi where I was born is a relatively good wage, and it may make some sense to say that someone making $17,000 a year in Mississippi is not indigent.

Connecticut, as you well know, is one of the most expensive States in the Union, and $17,000 a year here is not the same as in Mississippi.

Mr. **Morrison**. So you would suggest we do regional variations in that area, as well?

Mr. **Browne**. Precisely.

Mr. **Morrison**. Thank you very much. Mr. Rowland?

Mr. **Rowland**. I pose my first question to Mr. Browne and give you an opportunity to make a comment on the plan to consolidate, for lack of a better term, the services between West Haven and Newington. Mr. Davenport made reference to the plan and seemed very supportive of that. I would like to hear a word of comment from you and give you a chance to say what you think.

Mr. **Browne**. Mr. Rowland, I think that's actually working. We have made a couple of errors in that, where individual patients have not been dealt with well. But given the number of patients that we're dealing with, I believe that concept is sound, the concept is that tertiary patients, patients needing the most complex forms of care, will be brought by VA vehicle from Newington here. We will treat them and then return them to Newington. Patients who need geriatric care, certain types of psychiatric care, will be treated in Newington. I think the concept is sound, and so far, I think we're actually pulling it off.

Mr. **Rowland**. Have you made accommodations for veterans from outside this immediate area? I should say actually to both of you, to Mr. Davenport also, to veterans that are in the Newington area coming to West Haven, and veterans in the West Haven area going to Newington? Has that been addressed?

Mr. **Davenport**. For care, are you speaking of?

Mr. **Rowland**. For care.

Mr. **Davenport**. Yes, we have—for about 30 days now, we have been transporting patients back and forth. Our transportation system is on board. I personally have talked to about 20 percent of those veterans. Everybody seems very pleased with it. It is some inconvenience. Granting that, I think we are very fortunate here in the State of Connecticut that we have two VA medical centers 34 miles apart, and that we can utilize the services of both of them to expand the care to the veteran.

Mr. **Rowland**. Mr. Chairman, a follow up on a question you asked about the clinical addition. I don't know if Mr. Washko has seen the letter, but I sent a letter to the Secretary of Veterans Affairs and he sent me back a letter with support for the clinical addition, and made reference—and just for the record, I would like to have the letter submitted.

Mr. **Morrison**. Without objection, it will be made part of the record.

(See p. 87.)

Mr. **Rowland**. One of the references that Mr. Derwinski makes is a plan that would be permissable to include in the 1992 budget the possibility this project, if other additional projects are dropped off along the way in the budgetary process. And so I'd like to establish that in the record.

I have no further questions, unless somebody else would like to make a comment.

Mr. **Washko**. I would just like to applaud your initiative and support there, Mr. Rowland.

Mr. **Morrison**. We want to thank all four of you for your testimony and perhaps even more important, your day in and day out work on behalf of veterans operating as—Mr. Washko, you pointed out under very difficult conditions of reduced allocations of funds in light of real cost. We hope you'll continue to slug it out and won't be lured away by any of those fancy private sector salaries.

Mr. **Washko**. Thank you for all of your support.

Mr. **Morrison**. We would now like to call our next panel: Dr. Philip Bondy, chief of staff of the medical center here at West Haven; Mr. Joseph Russo, chief of the Medical Administration Service at the medical center here; Mr. Kenneth Veysey, president of Local 1674 of AFGE, representing employees here at the medical center; and Ms. Emma Soto, nursing assistant at the West Haven Medical Center.

Once again, I'd like to thank all four of you for making yourselves available to the subcommittee today. Written testimony that has been submitted will be included in its entirety in the record. We'd ask you to summarize your points that you want to make as briefly as you can, so that we might also an opportunity to ask you question.

Dr. Bondy, if you'd proceed.

STATEMENT OF DR. PHILIP BONDY, M.D., CHIEF OF STAFF, DVA MEDICAL CENTER, WEST HAVEN, CT

Dr. **Bondy**. Thank you, Mr. Morrison and Mr. Rowland. I appreciate the opportunity of coming before you and mentioning a few of the problems that we see.

The main thing I'm going to talk about today has to do with recruiting and retaining qualified staff at West Haven VA. Some types of staff we have no trouble recruiting. We can recruit physicians, but the reason for this is that all of the physicians we recruit are on the staff at Yale. The prestige of Yale makes it possible for us to bring these people into our own orbit. Moreover, Yale very generously provides supplemental income through teaching agreements so the income of our physicians is competitive with the community physicians' salaries.

However, as our VA salaries fall further and further behind, this is becoming a burden on Yale, and they are beginning to mutter about how they can't really continue putting very large amounts of money into supporting our salaries indefinitely.

Our present maximum VA salaries in some instances run less than half of what the community or faculty salaries are for comparable services.

With respect to nurses, pharmacists and certain other types of clinicians, we had trouble recruiting, but this is not such a problem anymore since we have been granted special pay. It may become a problem again if the local hospitals begin to bid up the costs. Right now, we can fill our staff.

However, we have a problem. For example, our chief nurse is being paid less than many of the nurses on our staff, because she doesn't get special pay.

We also have trouble, and you'll probably hear more about this, I expect, in finding appropriate ways of compensating our nursing assistants.

But the place where we have the most difficulty is in recruiting engineers, maintenance specialists, clerks, operational administrators such as service chiefs, and Mr. Browne has mentioned this earlier.

I believe that at this point, the level of clinical competence in this hospital is entirely comparable to that at Yale New Haven, and that a patient who comes in here will have the kind of service he could reasonably expect at Yale New Haven. In fact, our physicians and our house staff are all partly at Yale New Haven and partly here. They rotate between the two.

On the other hand, we do have a lot of trouble getting the support necessary to make this kind of clinical competence work smoothly. For example, we have trouble getting medical records that are up to date. There is a terrible slowdown in the filing of the laboratory tests, X-rays, and so on, in the patient's records. I say this without any intention of indicating deficiency on the part of the people who are doing the work. It is simply that there aren't enough people to do the work fast enough to keep up with the flow of information. You can imagine the frustration of a physician who faces a patient without a clinical record that tells him what's been done and what the patient's past history is.

We have trouble keeping equipment running. We are spending a great deal of money for outside contracts to maintain equipment.

At the present time, these deficits are filled in to a considerable extent by having physicians, nurses, dentists, do work which should be done by clerks and porters, such as running errands, moving patients on litters, sometimes taking out the laundry. This is a very poor way to use highly trained staff whose salaries run from $50,000 to $100,000 a year. We really need to get the infrastructure properly compensated so we can have an adequate staff at all levels.

Thank you very much.

[The prepared statement of Dr. Bondy appears on p. 88.]

Mr. MORRISON. Dr. Bondy, thank you very much.
Mr. Russo.

STATEMENT OF JOSEPH RUSSO, CHIEF, MEDICAL ADMINISTRATION SERVICE, DVA MEDICAL CENTER, WEST HAVEN, CT

Mr. RUSSO. Thank you, Mr. Morrison and Mr. Rowland. Good afternoon.

As Chief of Medical Administration, it's the responsibility of my service, among other things, to provide clerical support to physicians and nurses, and to maintain the quality of medical records. My service, as you've already heard, is also having difficulty recruiting and retaining personnel.

As any major hospital accreditation organization will attest, the single most important factor in the provision of quality health care is not, as most of us believe, the skills of physicians and their qualifications, although extremely important, but the existence of a well documented and maintained medical record. At this medical center, we pay file clerks, who are the employees responsible for the hands on maintenance and delivery of medical records about $13,500 a year, or $6.50 an hour, which is below the VA's indigent level——

Incidentally, this is 50 cents more an hour than the rest of the VA, because we do have special pay rates for our file clerks. For $6.50 an hour, we require the file clerk to file about 160 medical records and 440 pieces of loose filing, answer about 30 telephone calls, search for 10 to 15 lost or missing records, and make one or two deliveries of medical records to a clinic area during the day. All of which, I might add, is done while standing on one's feet in a dusty, crowded, and windowless environment.

To put this more in perspective, in an 8-hour day, not allowing time for breaks or restroom calls, a file clerk must access a medical record every 48 seconds, while answering phone calls, and performing other miscellaneous duties at the same time.

Meanwhile, for this we pay them $52 a day. Meanwhile at a local supermarket, where your groceries are assured to be in peak health, high school students, who don't even have to know how to use a cash register or make change because they have laser beams and computers that do it all, make $7.95 an hour.

At this medical center during the last 12 months, we experienced a 288 percent turnover rate in file clerks. In spite of the fact that we have special salary rates, the majority of these losses were to higher paying, albeit less responsible jobs, in the community. Special pay doesn't solve our problem and simply doesn't work.

Thank you.

[The prepared statement of Mr. Russo appears on p. 89.]

Mr. MORRISON. Mr. Russo, thank you very much.
Mr. Veysey.

STATEMENT OF KENNETH VEYSEY, PRESIDENT, LOCAL 1674, DVA MEDICAL CENTER, WEST HAVEN, CT

Mr. VEYSEY. Thank you.

Good afternoon. My name is Kenneth Veysey, president of the local union, American Federation of Government Employees. I represent over 700 Federal employees in this hospital and the regional office in Hartford.

My testimony concentrates on the severe pay inequities that are directly related to the recruitment and retention problem at this hospital. These inequities are not only isolated to just the gap between the Federal and private sectors in Connecticut, but also within the entire VA system.

We are unable to retain qualified people right within the VA system due to the multitude of VA hospitals around the country offering lower cost of living areas with attractive pay raises for the exact same job.

It is also difficult to recruit and retain people from private sector employers who can offer significantly higher salaries and better benefit packages. A classic example of this is with the only elevator mechanic at this hospital. Last year, he obtained a State license for elevator repair. The VA system could not allow this man a competitive wage. Subsequently, he went to private sector employer with a more than 80 percent pay raise, fully paid health benefits, and a dental plan. The real absurdity here is that he now works 2 to 3 days a week here at this hospital on the same elevators as an outside contractor. This not only costs the taxpayers significantly more a year on this one salary alone, but it is one of the many examples of how the veteran is inconvenienced by not having the benefit of sufficient, full time, qualified employees for adequate health care services.

Thank you for this opportunity, and I would be happy to answer any questions.

[The prepared statement of Mr. Veysey appears on p. 90.]

Mr. MORRISON. Mr. Veysey, thank you very much.

Ms. Soto.

STATEMENT OF EMMA SOTO, NURSING ASSISTANT, DVA MEDICAL CENTER, WEST HAVEN, CT

Ms. SOTO. Mr. Chairman, members of the committee, good afternoon.

I would like to thank you for this opportunity to speak to you on behalf of the nursing assistant of U.S. Department Veterans Affairs Medical Center at West Haven, Connecticut. My name is Emma Soto. I am chairperson of the Nursing Assistant Advisory Committee. This committee was formed in 1985—1986 to facilitate communication between nursing assistant and the chief for nursing services and this medical center.

I have always indicated my support and concern for nursing assistants. As a nursing assistant for the Federal Government, our duties and responsibility encompass far more than the duties and responsibility of nurse's aide in the private sector. Yet our wages are much, much lower than the wages received by the nurse's aide.

Most of us would cherish the opportunity to further our education, so that we could improve our status. However, about 90 percent of us have to work two jobs in order to support our families. This eliminates available time for furthering our education.

As you know, there is a nationwide shortage of nurses. As a result, they have been able to gain salary increases far beyond expectations. It has been said there is no shortage of nursing assistants and therefore no wage increases.

Low wages have caused a large turnover rate and a low morale among the nursing assistants. Nursing assistants are the backbone of the care the patients receive at this hospital.

In conclusion, I would like to say that I am deeply concerned as to what the future holds for us in the 1990s. Will nursing assistants be phased out of the Federal Government hospitals? Or will their salary be increased to a level at which they will be competitive with the private sector?

Thank you.

Mr. MORRISON. Thank you all for your testimony. Mr. Rowland, do you want to go first this time on questions?

Mr. ROWLAND. Sure.

Ken, I think I am going to go right to you first. I think everyone was intrigued with the example that you used. I guess the first question I have with regard to the elevator operator was what was the decision making process in that? Was it the administrator, was it a regional decision, as far as you know?

Mr. VEYSEY. No, as far as I know, there are certain classification guidelines that allow—you have to have certain responsibilities to gain a certain grade or level in the Federal sector. With his qualifications, he was an excellent elevator mechanic by getting his State license. But still, it didn't allow him to gain anywhere near the wage that he would get in the private sector.

Mr. ROWLAND. So he did not have his State license before——

Mr. VEYSEY. No.

Mr. ROWLAND (continuing). When he worked for the hospital?

Mr. VEYSEY. Right.

Mr. ROWLAND. He got a State license, left, and went in the private sector. The hospital contracted out for the elevator service.

Mr. VEYSEY. Yes.

Mr. ROWLAND. Who made the decision to contract out?

Mr. VEYSEY. I don't know; that's management.

Mr. ROWLAND. This was all done in the last year or two?

Mr. VEYSEY. Yes.

Mr. ROWLAND. Do you agree that part of the solution is the regional flexibility that can be applied to pay across the board, not just in particular categories, but in all categories?

Mr. VEYSEY. Yes. We do have a wage survey. We come out with the statistics that we need. It just has to be applied.

Mr. ROWLAND. Do you have a wage survey underway right now and/or some other information being compiled?

Mr. VEYSEY. We just have completed a wage survey for this year. The information goes to Central Office. They use benefits and things like that, they add a dollar figure to it, and then they come back with the statistic as to what the private sector is making in Connecticut.

Mr. ROWLAND. Is one of the problems the fact that when the survey is done, the information is sent to Central Office, then probably the OPM, and then it probably is delayed for quite a bit of time? I know that in past experiences, we have seen sometimes as much as 15 months before the information or the decision comes back. By that time, you're another year behind.

Mr. **Veysey**. Well, as I've been employed in the Federal sector, after the wage survey we do get a notification within just a few months, 3 or 4 months. The problem is that we—since I've been here, we've been capped by public law. President Reagan has capped us at 2 percent, so no matter what the wage survey came out with, we still got 2 percent. And in a notification of personnel action that we get as an employee, it states that if not capped by this—these two public laws, that our salary would be. That's the worst part of it. That shows right on it this is what you should be making, but this isn't what you're going to get.

Mr. **Rowland**. So we need to move around the cap, we need to bring forward the wage information. We have some of the highest housing costs, and some of the highest costs of living in the entire Nation. I have seen the special pay, obviously, used in some circumstances. But you contend that we can—would you agree with—as Mr. Browne that mentioned earlier, apply flexibility on a regional level. Would you support that?

Mr. **Veysey**. Yes, sir.

Mr. **Rowland**. Emma, one quick question. We have some legislation pending in the committee. One is H.R. 901, which was put forward by the Chairman of the Veterans' Affairs Committee. It addresses the recruitment and retention problems. It gets into authorizing, for example, Saturday premium pay for licensed practical nurses and nursing assistants. Is that a step in the right direction?

Ms. **Soto**. Yes, it is.

Mr. **Rowland**. Are you familiar with that legislation we have pending in the committee——

Ms. **Soto**. No.

Mr. **Rowland** (continuing). With regard to special pay and nurses?

Ms. **Soto**. Well, I understand there is a special pay for the nursing assistants.

Mr. **Rowland**. Well, we have a lot of different issues covered in these two pieces of legislation that we have before us, and perhaps at some point after the hearing, we can get that information to you for comment as we go through the process.

I have no other questions. I would just like to thank you all for being here and voicing your concerns, and have a willingness to stand up and represent not only the hospital, but the many employees that are here. We appreciate that very much.

Mr. **Morrison**. First, Ms. Soto, I'd like to—just following on what Mr. Rowland has said, you and I have met on this—many of these issues, and worked on it at various levels here at the local level. I've tried to work on it in Washington. And I want to thank you for helping to educate me to the problems that exist for nursing assistants.

I was asked some questions about this Saturday premium pay issue at a hearing that we had with the very top leadership of the VA at a hearing, and they, frankly, did not understand that because you are Title 5 employees and not Title 38 employees, some of the things that have been done for LPNs and for registered nurses are not available to try to address equity and retention in terms of nursing assistants.

So although it may seem, at times, that it's a very big bureaucracy and nothing happens, we are getting some greater understanding. And as Mr. Rowland pointed out, there is some legislation to make some small changes, at least, to try to deal with some of the inequities.

So your testimony today and your input in the past has certainly been very useful in that regard.

Mr. Veysey, I'd like to ask you to tell me a little bit about the participation of the union in proposals and programs to upgrade people who are currently working here at West Haven and the possibility of their coming into higher technical grades and to earn some higher salaries. Could you just tell me a little bit about that?

Mr. **Veysey**. Well, last year was my first wage survey. That's where I really got involved in the groundwork and found out exactly who we were seeing in Connecticut to make sure we were getting comparable wages. When I found out how bad things really were between private and Federal sector, I've worked with the administration in the hospital, and I've written the Central Office. I've written to other legislators. We can just keep trying to get legislation changed, and I think working with Mr. Browne and the hospital administration, we can direct the most severe problems to the certain sections that really need it. And I'm really happy with the help that I've got from this administration. And we're really working together to get better pay for the people here and to also have better care for the veterans in this hospital.

Mr. **Morrison**. Mr. Russo, and Mr. Veysey may want to chime in on this as well—I had really the first occasion to focus on the wage employees as opposed to the salary employees and the way in which their salaries are both capped and limited in their increases to the cost—to an overall cost of living across the Government, and also to the delays that occur.

I think most people in Washington, when we approve a cost of living increase for all Federal employees, it goes into effect usually on January 1st. We make the assumption that everybody gets that pay increase on January 1st. And I guess that's true of the salaried employees, but with respect to those who are on wages and are on the comparability study, could you just tell us what the time frame is in terms of how it actually comes out that an employee like Mr. Veysey or Ms. Soto, how it actually comes down in the end?

Mr. **Russo**. Actually, I'm not familiar with the amount of time it takes for the wage survey people. The medical administration service does not employ any wage survey people.

Mr. **Morrison**. Mr. Veysey, perhaps you could—

Mr. **Veysey**. The wage people are basically engineering, dietetics, and building management. Their increases become effective—I'd say last year was October or September.

Mr. **Morrison**. Of the year following the January 1st that salaried employees got their cost of living increases?

Mr. **Veysey**. No. If the GS people get it in January, we see it that following—

Mr. **Morrison**. The following, 9 months after—

Mr. **Veysey** (continuing). Seven months or 8 months—yes.

Mr. **Morrison**. And—

Mr. **Veysey**. Why, I've never got any answers on it.

Mr. **Morrison**. Well, originally we went to comparability because that was supposed to allow wage employees salaries to go up more than the general cost of living, because that was the notion of lack of comparability.

What's happened, though, is that since it's been capped, you've gotten the worst of both worlds. You get the comparability study first, you get all of the delay, and none of the increase. I think people will be familiar with that Catch-22 concept.

I want to thank you all for this input and for taking the time to testify today, and for your very informative testimony. Thank you very much.

Our next panel, if you'd please step forward, is: Dr. Paul Errera, Director of Mental Health and Behavioral Sciences for the Department of Veterans Affairs; Robert Rosenheck, M.D., national director, Evaluation of the Homeless Chronically Mentally Ill Veterans Program for the Department of Veterans Affairs here at West Haven; Ms. Cynthia DeLouise, executive director of Columbus House, a facility for homeless individuals in New Haven; and Mr. James Hill, representing chapter 251 of the Vietnam Veterans of America.

I want to thank you all for coming today. I want to particularly thank Dr. Errera, who we claim as our own here in the New Haven area, but who has made a special trip back from Washington in order to be with us today. We very much appreciate all of you coming and sharing your testimony.

Dr. Errera, if you would go first.

STATEMENT OF DR. PAUL ERRERA, M.D., DIRECTOR OF MENTAL HEALTH AND BEHAVIORAL SCIENCES, DVA

Dr. **Errera**. Thank you, Mr. Morrison and Mr. Rowland.

I'd like to pay tribute to the excellence of the people responsible for veteran care in this State from the regional director on down. The creative efforts that you've heard about to integrate the two medical centers hopefully may become an example to the rest of the Nation.

One point I'd like to make is to underscore the importance of one facet of the West Haven VAMC activities and that is the work of the Northeast Psychiatric Evaluation Center, which is directed by Dr. Rosenheck, to whom I'm going to give my time. He is really functioning as a national resource for mental health and behavioral sciences in terms of the number of national evaluations he's doing with the homeless program and for PTSD.

[The prepared statement of Dr. Errera appears on p. 91.]

Mr. **Morrison**. Dr. Rosenheck, thank you for being here. I'd appreciate hearing your testimony.

STATEMENT OF DR. ROBERT ROSENHECK, M.D., NATIONAL DIRECTOR, EVALUATION OF THE HOMELESS CHRONICALLY MENTALLY ILL VETERANS PROGRAM, DVA

Dr. **Rosenheck**. It is a pleasure to appear before you today and provide you with information about our work here at West Haven and for the country.

I am here actually representing among the most under-served citizens in our society. Behind me are 160,000 chronically disabled veterans who were served in VA inpatient programs last year, over 470,000 veterans who are suffering from chronic post traumatic stress disorder from their service in Vietnam and a greater or equal number from our other wars. I'm representing well over half a million homeless veterans who are living on the streets of our large cities and uncounted veterans living in rural areas. And in addition, I represent countless veterans and uncounted veterans who are suffering from the major plagues of our time involving alcoholism and drug abuse.

The VA in this country is a major provider of mental health care to the poor and under-served. Our preliminary data suggest that between a third and a half of all veterans receiving hospital care and outpatient care for psychiatric disorders receive it from the VA.

The VA, as the rest of American health care, has experienced and continues to experience major transition in its delivery of health care services, both in its mainline services and its efforts to serve the under-served. Our group, with the sponsorship of Dr. Errera and Mr. Washko, has been monitoring these changes and assuring that the services to the under-served are delivered as planned.

A few points I want to mention about four of the areas we've been involved with. In 1984, the VA instituted a DRG based budgeting system, which has in many ways changed the face of VA health care. We were asked by the Congress to report on that, and two findings I want to share with you.

First of all, there was been a 36 percent decline in the length of stay, the number of days per episode received by veterans seeking psychiatric care in the VA. While on the one hand this represents a major increase in efficiency, it has been accompanied by an increase in the readmission rate of between 5 and 8 percent.

On the other side, I want to tell you about some of our innovative programs. In the northeast region, we have developed a pilot program of intensive case management for the most seriously ill of our veterans, those who are the highest hospital users. In this program, social workers and nurses with the backup of psychiatrists go out and serve these veterans in their community, seeing if we can make a major turn around in the course of their lives.

Another program is the Homeless Chronically Mentally Ill Veterans Program, a program initiated by the Congress in 1987, which has up to this date served 18,000 homeless veterans in 43 sites across the country. While we are still putting together data on the outcome and efficacy of this program, I can tell you at this point that these homeless veterans are extremely poor, unemployed, and 25 percent of them have been homeless for over 2 years.

A second program we have been monitoring is the Domiciliary Care for Homeless Veterans Program. Located at 20 sites across the country, this program provides residential rehabilitative services for homeless veterans, and up to this date has served about 5,000 veterans in those inpatient facilities.

Let me stop there.

[The prepared statement of Dr. Rosenheck appears on p. 93.]

Mr. **Morrison**. Fine, thank you.
Ms. DeLouise.

STATEMENT OF CYNTHIA DELOUISE, EXECUTIVE DIRECTOR, COLUMBUS HOUSE, NEW HAVEN, CT

Ms. **DeLouise**. Good afternoon. My name is Cynthia DeLouise, and I've been the executive director of Columbus House, Inc., an emergency shelter for homeless men and women, for the past 8 years.

Columbus House shelters over 2,500 different individuals each year, and approximately 20 percent of those individuals are homeless and veterans. The majority of these individuals suffer from problems related to post combat stress such as alcoholism, substance abuse, and mental illness. The fact that these problems often stem from trauma directly related to their experiences in the military makes this a population with very special needs.

The VA hospital in West Haven offers an array of programs designed specifically to help veterans. Some of these programs are extremely beneficial and effective. Our case management unit at Columbus House has had tremendous success in making referrals here. These include the detox facility and 28 day drug and alcohol treatment programs, as well as the halfway house programs. Many of our guests finally are enjoying a successful new beginning as a result of these programs.

One of the ways in which the substance abuse program at the VA could help homeless veterans is to do active, on-site outreach to our homeless veterans' need for services. So far to date, the only services that are provided are the ones I've mentioned. And still in this area, there is a great lack of services to the homeless population and to the veterans in the Greater New Haven area.

Other outreach programs have been extremely beneficial to our guests who may never request services of their own. Often all it takes is for someone to come to the shelter to spend a little time and to show some sense of concern. And also by providing services on site, I think there would be a direct result with more admissions and in the number of people taking advantage of services, as I said, who wouldn't otherwise be able to.

In February of this year, our staff met with officials from the Veterans' Adminstration to discuss a new shelter program for homeless veterans. A program such as this would be invaluable to homeless veterans, not only because of the obvious need for shelter, but because they would be better served if they were staying in an environment designed for the special needs of veterans. We were hoping that there would not only be more inpatient beds created, but that we'd have an opportunity to refer individuals here in an emergency and in a crisis. This was what we had initially been told. At this point that has never come to fruition.

To date, it has not happened, and we've been unable to take advantage of at least overnight referral, when we were told that there was a number of open beds available, maybe perhaps not for this population, but there were a number of unused beds in the hospital.

To date, all such individuals are referred directly to Columbus House because no other programs exist, nor does any transportation for programming in the Greater New Haven area.

We are also waiting word from the VA as to whether additional grants have been received for additional care, whether it be clinical care or whether it be—we've discussed the domiciliary program, but obviously other programs need to happen in the Greater New Haven area.

Again, Columbus House continues to be the only possible shelter provider for homeless veterans and is in the process of planning transitional supportive living programs. Homeless veterans will be welcomed and encouraged to apply for these residential facilities.

I appreciate having the opportunity to be here. Thank you.

Mr. MORRISON. Thank you

Mr. Hill.

STATEMENT OF JAMES HILL, CHAPTER 251, VIETNAM VETERANS OF AMERICA

Mr. HILL. My name is James Hill. I'm a member of Chapter 25, Vietnam Veterans of America, and I serve on the State Council for Vietnam Veterans in Connecticut.

I have a few brief comments and some general comments I would like to make to you on homeless veterans. We as a chapter are now just getting involved in the program, because we as veterans are just now finding out the magnitude of the problem that we face. And I say "we" because we are all a part of the problem and we need to be a part of the solution.

I'm here today to ask your help in resolving a national tragedy, homelessness among Vietnam veterans. This problem has been identified without question as being real, and now we must pool our resources to find a solution. Approximately 30 to 40 percent of the homeless in this country are veterans who served to protect the dignity of people, and they are losing theirs. By remaining silent or just applying a band-aid, we are contributing to this growing problem, and we are doing a disservice to those men and women who sacrificed so much. To ask them to give of their lives and not to assist them in meeting the basic needs of life, in my opinion, is criminal.

A tremendous number of Vietnam veterans, some estimates show 600,000, suffer from some form of post traumatic stress disorder, PTSD. And as you heard, out of that number, we are told today that 18,000 have received some treatment.

This can lead to substance abuse and ultimately a breakup of the family, which can be attributed to a frequent cause of homelessness. There has to be an aggressive approach to the treatment of PTSD. More funds have to be allocated to reach these people through programs and facilities that not only offer hope, but achieve results.

Mental illness has been recognized as one of the leading causes of homelessness among veterans and others, and yet we have no reliable estimate of the number of mentally ill on the streets.

Hearings held in mid-1988 revealed that the VA, because of its financial situation, could not afford to help all of the veterans with medical problems. Accessible medical care has to be addressed because short and long-term medical problems that are not resolved can lead to job loss, which can lead to homelessness.

Without good numbers, you in Congress are not able to allocate funds in an effective manner. Funds have to be allocated and programs established that will not only provide shelter and medical help, but also ongoing follow-ups to insure long-term positive results.

I ask you to assist us in providing the quality of life that these valiant men and women not only need but deserve. They paid a tremendous price and it is our turn to repay the debt we owe. Vietnam veteran organizations around the United States are working to reach these veterans through various means.

As I said, I belong to chapter 251 here in Connecticut, and we have committed ourselves to identifying the magnitude of the problem in our area. We hope to be able to help in any way we can, but we cannot resolve the problem alone through scattered programs. We need your help.

I thank you for the opportunity to be here today, and I look forward to working with you in reaching a positive solution to this epidemic we face. Thank you.

[The prepared statement of Mr. Hill appears on p. 95.]

Mr. **Morrison**. Thank you very much. I thank all of you.

First, Ms. DeLouise, you said something about the local situation. I'd like to focus on that for a moment, in terms of what you are and are not able to look to this VA medical center for. You've said that you need more active outreach. Is that correct?

Ms. **DeLouise**. Absolutely. I think that would enhance our programs, and I think it would be veterans working with other veterans, which would be really important. Or the psychiatric and clinical backup that's desperately needed on site.

Mr. **Morrison**. The second thing you said is you'd like the ability to refer people for a place to stay while they are getting some of these services, at some domiciliary program, or at least a clinically based referral. Is that accurate?

Ms. **DeLouise**. That's absolutely accurate.

Mr. **Morrison**. Dr. Rosenheck, could you comment on that and what is possible, what's not possible, and why?

Dr. **Rosenheck**. Well, I can first comment Cindy is absolutely right. That's what we need, that's what we want to do. We have applied for both of the programs that I'm representing nationally, we have applied locally. And what can be said is that there's no suggestion of any conflict of interest, because we were not funded locally.

Mr. **Morrison**. We're going to come to you in a minute. But we want to find out from the local folks exactly what it is we need. Go ahead.

Dr. **Rosenheck**. Both programs would be perfect for this setting, having outreach clinicians going to the shelter. Cynthia and I have met and discussed this. Outreach clinicians going to the shelters, making relationships with funds available for placing veterans in contract residential treatment; we need that. It would be ideal if we had staffing and resources to establish a domiciliary for the homeless. We know exactly what to do.

Mr. **Morrison**. Exactly—Dr. Rosenheck, exactly what is your job nationally as opposed to Dr. Errera's job with respect to making this come about in any given community?

Dr. **Rosenheck**. I have minimal role in making it happen nationally. That's more Dr. Errera's job. My role is once these programs are funded, assuring that the programs are reaching the target population in need, and that the Congress has appropriate information on them.

Mr. **Morrison**. You're an evaluator—

Dr. **Rosenheck**. Exactly.

Mr. **Morrison**. And Dr. Errera is the manager.

Dr. **Rosenheck**. Right.

Mr. **Morrison**. So let me turn to Dr. Errera. If you can tell us why we don't have the program at this point in this area, and what it's going to take for us to have it here. I assume there are many areas of the country that have similar needs that are being expressed that don't have it. What are the choices that are being made to force this result?

Dr. **Errera**. Well, let me backtrack a minute and say that we have a problem with the health system in America, which is what some of us call a passive health care system. You have to be healthy enough and capable to navigate your way to the right clinic on the right day and hope that the chart and the doctor are at the same place. That's something that a lot of veterans, or a lot of people, a lot of Americans can't do, if they happen to be poor, if they happen to be elderly, if they happen to be alienated such as PTSD patients. The people we're talking about are all three of these things.

So there is a need for a different kind of health delivery system for this particular population. VA, I would say, is ahead of a lot of the country in its attempt to shift to outreach activities. The Vet Centers, this HCMI program, and a hospital based home care program are examples of this. However, they represent a small fraction of the overall national budget.

I think what's exciting about what we're doing is that, as Dr. Rosenheck pointed out, we do know what to initiate. As a matter of fact, based on the first 2 years of our work, we have some recommendations which we hope the Congress will look favorably on. The Senate is already introducing some laws to strengthen our ability to deliver care for this population.

So we know what to do, we know how to do it. The question then is, is there the will? I can function as far as the budget that's given to me. We initially were given $5 million for HCMI and we had something like $16 million worth of requests from 92 VA facilities. Our budget is up to $13.32 million this year, which is a nice increase, but it still only funds 43 places in the system.

Mr. **Morrison**. So the answer to my question is we don't have the money at this point. It's a competitive process, it's not a program that is generally available at any VA medical center?

Dr. **Errera**. That's right. West Haven applied but was not rated high enough in the elaborate review proces to be funded.

Mr. **Morrison**. Mr. Hill, we focused for the moment on this particular area, the Greater New Haven area. But you've looked at it across the State of Connecticut, I know. Could you say something about whether the situation is worse or better, or where it's most severe in the State?

Mr. HILL. We're finding that the problem is bad. It's worse than we had anticipated. The service that has been provided, as has been stated, is not meeting the need. There are many veterans out there who for one reason or another, will not get to the clinic. Even if the clinic were here. We need to find some way to get the clinic out to the patient and let them know what's going on.

There's a lack of trust on the part of many veterans in dealing with bureaucracies. They will only deal with other veterans, and in some cases, we have trouble with them dealing with us, because sometimes they perceive us as part of the system.

The problem in this area, as I said, we're new and we're beginning our research, but we're finding that it is a tremendous problem in the Greater New Haven area and throughout Connecticut. We have people coming into this State, moving in from other parts of the country as I did. I'm a transplanted veteran, as—with Mr. Browne, I'm from Mississippi. The economy has been addressed earlier in the testimony. This is a very expensive place to live. Even if you make a wage that's considered decent in other parts of the country, you cannot survive here. A lot of veterans are finding this to be a major problem when they get here and they don't know where to turn or where to go.

We deal with veterans who see bumper stickers on our vehicles, or see our jackets when we're out to a meeting, who come up to us and express their problems to us. They ask: "What can we do? Where can we get help?" Just by being out on the streets ourselves, we're finding out that there are a lot of veterans out there with problems.

I deal with Federal funds in programs myself on a daily basis, and I don't believe in just throwing funds at a problem. We have to get reliable figures, as I said, and I don't think we have them. You can read all the estimates from one group to another, and you'll hear that there's 83,000 homeless veterans from one person, you'll hear that there's a million from another.

We're trying to find out exactly in Connecticut how many there are. If there's only one, that's the one person we want to serve. I'm not as concerned if there are 3,000 or 4,000 or 5,000. I'm concerned that there's a problem, and that problem has to be addressed and that problem has to be resolved.

All of us at this table and everyone in this room need to get together and work out viable solutions—not "this program, that program, my program does this and my program does that." We need a program where we can all work together, where we can meet the needs of the veterans. We, as veterans, can go out on the street and pull them in and talk to them, and get them in here and get them some help.

My contemporaries tell me of a call we got the other day. We keep an answering machine in our office. A young man called in who had the phone in one hand and a .45 in the other. He was ready to go. Fortunately, somebody got to him in time. He didn't know where to turn except our phone number. He should have some better resource than our telephone number and answering machine to get help.

Thank you.

Mr. Morrison. Thank you. Dr. Errera, you said you're up to $13 million. How many dollars would it have taken in this fiscal year to fund all the applications you received that you would say were quality applications where, as Mr. Hill said, it wouldn't have been throwing money at it, but the money could have been well spent, wherever the application was coming from?

Dr. Errera. I would say that if the McKinney Act were fully funded during the coming year and we were to get $15 million additional—

Mr. Morrison. $50 or $15?

Dr. Errera. $15.

Mr. Morrison. In other words, $28 million? Is that—that would fund all of the applications that you got in fiscal 1989 that deserved to be funded?

Dr. Errera. Well, yes. That would be more than adequate.

Mr. Morrison. A lot of the problems these veterans face is a PTSD problem, which may exist in people who are not homeless yet. but whose homelessness is a potential result of the lack of treatment for their disorder. To what extent are we meeting that need, and what can we do to meet that need before we're dealing with a homeless population which adds to the disorder all kinds of other problems?

Mr. Hill. I think I can start by pointing out what was said here today. There are over 600,000 people who suffer from some form; 18,000 have been treated. I think that answers the question, we're not meeting the need.

Dr. Rosenheck. The Research Triangle Institute study shows that among Vietnam veterans with PTSD, the incidence of at least one day of homelessness was six times higher, I believe, than in non-theatre veterans. So it really is a risk factor.

In our group, we have fortunately found that among the 18,000 homeless veterans we have seen, there is not, in fact, an over-representation in that group of theatre veterans. So there is an increased risk, but among the homeless, there is not an over-representation.

What needs to be done is more of many of the things that we are doing. The vet centers are a very strong program. They need to be supported. In a certain sense, they led the way in community based outreach.

The HCMI outreach program reaches out to those who are already homeless and some who are at risk of homelessness. And a very important part that we are just starting to get involved with is specialized PTSD clinical teams. That is a $5 million program funded last fall that will be getting underway in the next number of months at 23 medical centers across the country. And we will know after our experience with those programs how effective they are and what the need is.

I believe that there were 80 applications for those, 23 of which were funded.

Mr. Morrison. Dr. Errera, anything you'd want to add about the prevention side?

Dr. Errera. No.

Mr. Morrison. Okay. Mr. Rowland.

Mr. Rowland. Thank you, Bruce. I just want to clear up a few things. Number one, Dr. Errera, you seemed to imply we needed another $15 million from the Stewart-McKinney Homeless Act, but in essence, the money has been authorized but not appropriated yet, so you have not received any money.

Dr. Errera. That's correct. When we do get the money, the question is, will that $15 million be in addition to or instead of.

Mr. Rowland. I think we need to clear that up. From your statement, I think some would anticipate that you meant that you got $15 million and hope to get another $15 million.

Dr. Errera. No, you're right.

Mr. Rowland. You have not received any funds from the McKinney Act. You are anticipating $15 million. Now the big question is, is the $15 million in the bag in the hopes of additional funding? I guess that's something we will have to address.

Also in 1989, Veterans Health Service and Research Administration supported a program with about $13 million, is that correct?

Dr. Errera. That's right, that's out of medical care funds.

Mr. Rowland. That's more the base of your activity right now?

Dr. Errera. That is the base of my activity.

Mr. Rowland. Obviously, you're hoping for the $15 million from the McKinney Act—

Dr. Errera. Yes.

Mr. Rowland (continuing). Once it's appropriated.

Dr. Rosenheck, is there a lot of interaction with the outreach centers? Is there a lot of interaction with Ms. DeLouise's organization?

Dr. Rosenheck. We've had a fair amount of interaction of various people from the medical center in touch with some of the veterans there, as well as some of the staff. It is not a structured program of the sort that we would both like to see develop.

Mr. Rowland. Would you like to comment?

Ms. DeLouise. Yes, I would like to comment. I think that last year when the money began to flow in many different areas, there was an outpouring of more interest on behalf of the entire United States for homeless people, and I found that to be the same with all categories of the Stewart-McKinney money. Last year was the first time, I would say, that we became very active in collaborating around a proposal to create additional services. Again, it wasn't funded, and that was the case this year.

We did, indeed, have one particular caseworker, social worker, I'm not exactly sure, that I've been told is no longer here, who was doing a lot of outreach on site. But yet I found that the most important problem we've had can be identified as not having one specific person to deal with, or just have a collaborative effort around the numbers of people who need services.

Our use of inpatient services is phenomenal because there is a need, number one, for that many services. But just our case management staff getting to the VA to say look, we've got these folks, you've got the beds, and that's worked successfully.

But I still think that we need the invaluable assistance of it on site.

I'd also like to mention that we have a health care clinic that's now been operating through the Health Center in New Haven from

Stewart-McKinney money, and we're using that at 110 percent. And, many of those individuals are veterans.

I think that there's ways to complement services rather than particular groups with their money utilizing only funding for their target group. I think there's ways to collaborate that. I haven't seen—I haven't seen it within the Federal Government, I haven't seen it within the State government. Clearly, I haven't seen it with the group that we're talking about today. I think a whole lot more could happen because of the lack of fully funded McKinney dollars this year. If we don't collaborate, there is going to be I don't know how many individuals not receiving services that could, indeed, receive services.

Mr. **ROWLAND**. Dr. Rosenheck, how many veterans did you serve last year?

Dr. **ROSENHECK**. In the HCMI program last year—let me say in the last 2 years, 18,000; and 5,000 in the domiciliary program.

Mr. **ROWLAND**. 18,000 veterans, different veterans?

Dr. **ROSENHECK**. Unique veterans nationally.

Mr. **ROWLAND**. How many in this region?

Dr. **ROSENHECK**. In the northeast region?

Mr. **ROWLAND**. Yes.

Dr. **ROSENHECK**. I don't have those figures off hand.

Mr. **ROWLAND**. Your responsibility is 11 facilities within the Northeast Region?

Dr. **ROSENHECK**. No, there are five HCMI programs in region I. I would estimate that about 2,500 homeless veterans have been seen in the northeast region.

Mr. **ROWLAND**. How many in particular in Connecticut?

Dr. **ROSENHECK**. None by these programs.

Mr. **ROWLAND**. Because we're still evaluating and—

Dr. **ROSENHECK**. No, because we were not funded. We submitted proposals, and there was a confidential review by a panel of experts and they elected to fund other programs.

Mr. **ROWLAND**. So until it's funded, until it's established, you can't do any—

Dr. **ROSENHECK**. No, Cynthia and I are singing the same song. Hopefully you heard the bass notes from somebody else, which is that we've had significant reductions in our social work—access to social work services here in the hospital. And so to yank someone free to devote them to full time outreach is impossible.

But I want to clarify one thing. What Cynthia and I are heading for together is not the answer. If you take Mr. Hill's phrase, that is still a band-aid. What we need is what neither of us have yet had a chance to talk about and that is residential rehabilitation. Getting the homeless to a physician does not resolve homelessness. This is a vicious cycle exacerbated through the years.

Mr. **ROWLAND**. I made reference earlier to H.R. 901 and also to H.R. 1199, which are two pieces of legislation pending before the committee which are somewhat comprehensive. One addresses special pay for nurses. The other authorizes discounts on hard to sell VA foreclosed homes for transitional housing as well as shelters. So there are a lot of things in the works. I hope in the process of this legislative year, that you get out and get some input on that type of legislation, as well as the extension that is coming up and is pending in the Senate. Things do look good there.

We would benefit from any counselor ideas you might have on this type of legislation to beef it up and make it better. We have a tendency on this committee to approve one massive piece of legislation to address a number of different issues. In that process, I would hope that the issues that you are concerned about would not be watered down, and that we would be making gains in those areas.

Dr. **Errera**. We have been working with Dr. Victor Raymond and his colleagues, just in the directions you're talking about.

Mr. **Morrison**. I hope you're working with the Appropriations Committee, too.

Dr. **Errera**. No, that's not a route that's made available to us.

Mr. **Morrison**. They write the checks, you know. We create the bank account, we try to, but they don't always put money in it.

Dr. Rosenheck, in terms of what you're saying, the residential rehabilitative treatment, is that the domiciliary program, or is that something beyond the domiciliary?

Dr. **Rosenheck**. We have three approaches to this. One is the contract residential treatment aspect of the HCMI outreach program. Two is the domiciliary program, and three is this innovative program that we're currently working on involving the access to community housing, which if I can add another sentence, is the most important thing. That is where we will start really addressing the problem, creating new residential rehabilitative units for the veterans, wherever they happen to be.

Mr. **Morrison**. Now, that's creating the housing and the services——

Dr. **Rosenheck**. That's right.

Mr. **Morrison**. What housing is being developed of that sort? Is this single room occupancy housing primarily, for single veterans?

Dr. **Errera**. The proposal is that we be able to buy houses and sell them, and renovate them—introduce therapeutic work for pay for the veteran who would be involved with the help of volunteers, retired painters, plumbers who are also veterans, so they can develop useful trade skills. The houses would range from 6 to 30 occupants.

It would also be linked to something called the Oxford House movement where veterans may remain indefinitely. In our therapeutic residences, veterans may remain only for limited periods of time—up to 1 year. Also, they would have to pay rent while living in these houses. They could pay rent, because they would have a job through our compensated work therapy program. This is all part of this package, which has grown out of the first 2 years evaluation that Dr. Rosenheck has done.

Mr. **Morrison**. What's the funding at the present time for that activity

Dr. **Errera**. There is no funding right now, but we hope that will be part of the $15 million from the McKinney Act, if it is counted as additional monies.

Mr. **Morrison**. Is there a need for the $13 million money that you are currently spending to be appropriated as part of a specific program in order to create the slots in which people work? It's been suggested to me by staff that there's a problem that you're basically taking money out of the medical program, and that you haven't created, really, a career path for people who want to go into that program. So they are constantly subject, in addition to private sector inducements for higher salaries, there's also a better VA job, or one with more job security that might pull people back out. Is that a problem?

Dr. **Errera**. Yes, sir.

Mr. **Morrison**. So we really should be getting the full $28 million or $30 million designated to the homelessness response program, rather than have it be borrowed, in a sense.

Dr. **Errera**. The Department has been eating itself, in a way. This is an example where they took $13 million out of their existing budget and gave it to us, reluctantly, as you would imagine, because there are needs everywhere. So yes, very much.

Mr. **Morrison**. Thank you very much for your testimony.

I'd like to call our next panel. The panel representing the work of the Yale Medical School here at the West Haven Medical Center. Testimony will be given by Myron Genel, M.D., Associate Dean for Government and Community Affairs, School of Medicine, Yale University. He'll be accompanied by Ashgar Rastegar, M.D., Chief of Medical Service at the medical center; Robert Soufer, M.D., Chief of Nuclear Medicine here in the medical center; and Dennis Charney, M.D., Chief of Psychiatry at the medical center.

I'd like to thank all four of you for being here. Dr. Genel, if you would give your testimony, and then I think we'll also have time for short statements of the three physicians who are with you, if they have particular points that they want to emphasize. And then we'll have questions.

Dr. Genel.

STATEMENT OF DR. MYRON GENEL, M.D., ASSOCIATE DEAN FOR GOVERNMENT AND COMMUNITY AFFAIRS, SCHOOL OF MEDICINE, YALE UNIVERSITY

Dr. **Genel**. Thank you, Mr. Morrison, Mr. Rowland. Thank you for the opportunity to speak to you this afternoon.

I am Myron Genel, a physician and member of the faculty of the Yale School of Medicine since 1971. I am currently an associate dean with primary responsibility for government and community affairs.

The West Haven Medical Center—excuse me, DVA Medical Center—has been closely affiliated with the Yale School of Medicine from the days that it opened a little more than 35 years ago in 1953, after the present buildings were constructed. Together with the Yale New Haven Hospital, the West Haven DVA Medical Center is a major teaching affiliate of the School of Medicine, and is an important component of our tripartite mission of teaching, research and clinical care.

In recent years, under the leadership of Dean Leon Rosenberg, the school's commitment to this affiliation has been reaffirmed and strengthened. Let me cite a few examples:

First when Dr. Stephen Waxman was recruited for the chairmanship of neurology 3 years ago, it was decided to construct the additional necessary laboratory space required on the DVA Medical Center campus. Out of that evolved what is now the PVA/EPVA Center for Neuroscience and Regeneration Research dedicated precisely 1 year ago. The chairman of this committee, Congressman Sonny Montgomery, was the keynote speaker at the dedication ceremonies, at which both of the distinguished Congressmen here today participated.

Secondly, arrangements have been completed recently for construction of a positron emission—tomography scanning facility, or PET at the VA using a combination of VA and private funding. This new center will represent a major institutional resource, the only such facility available between New York and Boston, and a major resource for clinical investigators at the School of Medicine.

Third, the Medical School's academic departments with significant involvement at the VA have likewise made major commitments by identifying as service chiefs and for other VA positions some of the most highly regarded and promising members of our faculty, such as the service chiefs who accompany me on this panel, Drs. Charney, Rastegar and Soufer.

Precisely because of these commitments, last fall Dean Rosenberg wrote a now widely circulated and often quoted letter which was sent to members of the Connecticut Congressional Delegation and to leadership of the Congressional Appropriations and Veterans' Affairs Committees. In this letter, the dean expressed concern that chronic underfunding of the VA medical care system was drastically eroding the quality of care, and thus the educational experience provided our medical students and residents.

If you'll permit me, I'd like to quote from that letter;

> As the funding for VA hospitals has slowly been eroded, the difference in quality of care provided at university and community hospitals on the one hand and the VA on the other has become more marked. We do not yet have a two-tier health system as reflected in the quality in the physician and nurse care received by our veterans. It does appear, however, that veterans are receiving inferior care as measured by the availability of ancillary support, the age and sophistication of equipment, the physical plant, and the lack of secretarial and clerical coverage. These deficits force an already overstretched physician and nursing staff to take time from patient care responsibilities to do things for the patient which in other institutions are performed by less expensive, more easily recruitable staff.

Please understand that these comments are not a threat to disaffiliate from the VA. Rather, they reflect a very reluctant realization on our part that we cannot allow our students and medical residents to participate in part of their training in an institution which is becoming substandard. If deterioration of the system is permitted to reach a level requiring disaffiliation, there would be a tragic loss of a major resource in American medicine.

This committee has been extremely responsive to these concerns, and we are very grateful. In particular, we salute your recent recommendation for a supplemental FY 1989 appropriation of $432 million, although we are aware that the final figure approved by the full appropriations committee was less, $340.1 million, and as of this date, has yet to be acted upon by the full House. Further, we fully support the committee's recommendation for a $1.3 billion increase to that originally requested for DVA health programs in the administration's FY 1990 budget proposal.

Dean Rosenberg and other members of our faculty have recently written to Members of Congress urging adoption of these numbers.

In this formal statement, I have chosen not to itemize a long list of problems, which in our view derive from insufficient funds. I will leave that to those in the trenches, such as my colleagues to the right. However, allow me to close by relating a personal vignette.

Thirty years ago, while a junior medical student at the University of Pennsylvania just beginning my clinical experience, my initial medicine rotation was split between the medical services at the university hospital and that at the nearby municipal hospital, the old Philadelphia General Hospital or PGH. There was an appalling gap between the services and facilities at the two institutions. I still remember what a totally depressing and discouraging experience it was for a young, perhaps naive, and idealistic medical student. Recognizing the mass of deficiencies, the city of Philadelphia closed PGH and tore down the buildings a few years later. I regret to say that I see many of the elements of the old PGH rising in our veterans hospitals.

I urge you to do all within your power to permit the West Haven Veterans Hospital to again become a premier academic medical center, not another PGH.

Thank you.

[The prepared statement of Dr. Genel appears on p. 96.]

Mr. **Morrison**. Dr. Genel, thank you very much.

Dr. Rastegar.

STATEMENT OF DR. ASGHAR RASTEGAR, M.D., CHIEF OF MEDICAL SERVICE, DVA MEDICAL CENTER, WEST HAVEN, CT

Dr. **Rastegar**. Congressman Morrison, Congressman Rowland, I am Asghar Rastegar, Chief of Medical Services at West Haven VA Medical Center and Professor of Medicine at Yale School of Medicine. I am also an attending physician in both this hospital and Yale New Haven Hospital.

My statement is brief and focuses on two concerns. One, as the clinical administrator, I'm disturbed when I see that highly trained professionals: physicians, nurses, technologists, etc., are forced to do clerical work because this medical center is not competitive enough to attract qualified individuals for these tasks. The most common complaint I hear from young physicians in training as well as nurses, is lack of adequate infrastructural support.

As the Chief of Clinical Service, I see the ever-increasing gap of salary between the VA physician and those at private hospitals, a gap that in certain specialties approaches 100 percent of the salary as an important impediment to recruitment and retention of excellent clinicians. Although we continue to provide high quality care to our patients, these issues result in deterioration of the working environment in this hospital and eventual departure of valuable personnel.

Thank you.

[The prepared statement of Dr. Rastegar appears on p. 99.]

Mr. **Morrison**. Thank you very much.

Dr. Soufer.

STATEMENT OF DR. ROBERT SOUFER, M.D., CHIEF OF NUCLEAR MEDICINE, DVA MEDICAL CENTER, WEST HAVEN, CT

Dr. SOUFER. Listening to the statements this afternoon, I've opted not to read my formal statement, since I don't think that's the best way to get the message across. So I'll be very brief.

It's obvious we don't make as much money. It's obvious that our delivery of health care is threatened to our veterans. But we're here because we have a unique opportunity to practice high level academic medicine in an environment where patients really need us. And that is the cornerstone of community service and government service. However, there is a limit. When I see my B.S. and M.S. trained technologists coming up from the South having to mop the floor to make ends meet, that's unacceptable. When I have to give standby pay to my technologists so they have to be on call just to be comparable to the technologists at St. Rafe's and at Yale, that's unacceptable.

It's unacceptable to hand write out reports on patients because there's not enough clerical help. We have a major problem.

Thank you.

[The prepared statement of Dr. Soufer appears on p. 100.]

Mr. MORRISON. Thank you.

Dr. Charney.

STATEMENT OF DR. DENNIS CHARNEY, M.D., CHIEF OF PSYCHIATRY, DVA MEDICAL CENTER, WEST HAVEN, CT

Dr. CHARNEY. My remarks are designed to reflect my commitment to providing top quality health care to our veterans.

I speak to you as a physician with clinical experience in a wide variety of treatment settings, including university, State, Federal, private, and not-for-profit facilities. In particular, I wish to point out that I and my psychiatric colleagues at the VA are strongly affiliated with the Yale University School of Medicine. This affiliation, in my opinion, has been of enormous benefit to both the VA Medical Center and Yale University. The VA does provide an exciting and rich environment to treat patients, educate students, and conduct research to further increase our knowledge of medical and psychiatric disease. The university provides the VA with doctors and students who are among the best in their profession and who routinely work long hours far beyond those that are expected and are paid for.

Therefore, I am committed to measures that serve to maintain the vitality of our Yale University affiliation. However, currently I'm concerned about the future of the affiliation and our ability to maintain our current quality of medical and psychiatric care at the VA Hospital because, as the other panelists have mentioned, of an inadequate salary structure and a decaying physical plant.

The salary structure results in the full spectrum of VA employees from the ward clerk to the physician being paid far below community standards. As a consequence, we have severe difficulty recruiting and retaining qualified, dedicated personnel. This problem adversely affects all aspects of daily patient care from housekeeping, to building maintenance, to nursing care, and to physician availability. I might add the current problem exists to the degree that the staffing of the psychiatry units are about 30 to 40 percent below community standards, and we are required to take care of patients that are, in general, more difficult to manage. The lack of funds and personnel are taking their toll on our hospital.

While personally I very much enjoy working at this hospital providing veterans the care they deserve, in order to continue to accomplish this, we must be able to recruit and retain qualified employees.

Thank you.

[The prepared statement of Dr. Charney appears on p. 101.]

Mr. MORRISON. Thank you, Dr. Genel.

Mr. Rowland?

Mr. ROWLAND. Doctor, the first question I'd like to pose is one I am sure my colleagues hear very often. It is a common complaint of many veterans. The complaint is that they never see the same doctor from one appointment to the next. It comes up all the time. And I'm intrigued with some of the comments that were made and some of the personal remarks that were made about commitment, salary structure, affiliation with Yale. And a certain level of frustration is, I think, built in for all of us as we grapple with some of these problems.

Someone said privately that perhaps the whole Federal system is falling apart. And we are doing our best to try and nibble away and come up with some of the solutions.

But let me center on that. The first question I posed to you is the complaint of many veterans as they go from one appointment to the next, and perhaps it takes weeks, perhaps it is months later, that they never see the same physician, and they get very depressed and frustrated. They don't feel that the interest is there. And I think that we have to be fair on both sides to observe that many of the doctors and assistants and technicians are straddled, perhaps, between both hospitals and trying to make ends meet. But can you address that concern right up front? I think we've talked about this privately before, and I'd like to view it publicly—

Dr. RASTEGAR. It's not fair to Dr. Genel. He doesn't run the service here.

Mr. ROWLAND. I'm sorry, I meant to pose it to you.

Dr. RASTEGAR. Okay. I think you're putting your finger on a major issue for all of us. We would like to provide personalized care, but have been unable to meet that goal. The reason has to do primarily with the structure of the VA historically.

The VA was organized to provide acute care, but it was not organized to provide long-term ambulatory care, to provide outpatient care in an efficient manner. It has become involved in that over the last 10 to 15 years, but has had a problem developing a structure that would fit that concept. As a matter of fact, for the first time this coming year, we are going to be providing an experiment in the medical services where appointments will be given by physician and time, and hopefully, the physician will remain with the patient for at least 2 years.

This is a problem in all training centers, that when you have resident and fellows rotating who are highly specialized, they remain with us for only 2 or 3 years. It is very difficult to maintain that continuity with that number of physicians.

We should also, I think, be aware that the number of full-time staff who provide care is relatively small for the population of patients that they serve. So if we have to provide primary care by the faculty for each patient, every faculty has to have clinic every day to do that. That's the reality in a teaching hospital.

But I agree with you that it is a problem. We are taking steps to face that, because I think that our constituents have to be happy with the care to support us. I think we're recognizing that at this time.

Mr. **ROWLAND**. Let me go a step further. So you are making movements to have physicians that are in training stay for at least 2 years. What is the average stay now?

Dr. **RASTEGAR**. Well, the average stay actually varies from specialty to specialty. But the question is, how long are you committed to clinics? Right now, the residents in training are committed to clinics for 3 years. So they should be available to the same patient for 3 years.

Those who are in subspecialties are available between 1 to 2 years—those who are becoming subspecialists in cardiology, nephrology, et cetera. So it varies from section to section.

Mr. **ROWLAND**. Let me go a little deeper. How long are they spending here in West Haven? In a typical week? Is it a problem of coordination? Is it a problem of tracking? Is it a problem of administration? If a doctor is here for 3 years, I am hard pressed to see how some veterans can complain that they never see the same doctor within a year's period of time.

Dr. **RASTEGAR**. We share the same doctors with Yale New Haven Hospital. So all the residents rotate through our system. They spend approximately a third to a fourth of their time at VA, and about three-fourths to two-thirds at Yale New Haven. Those are the numbers funded by us versus Yale New Haven. We get the exact share of what we fund, so that is usually the case.

Mr. **MORRISON**. If the gentleman would yield. I think the point is at the present time, you don't make physician-by-physician assignments of patients, isn't that right?

Dr. **RASTEGAR**. We do, but it doesn't work as well as it should. We do.

Mr. **ROWLAND**. Well, I shouldn't stay on this question, but I think it is an important one because I think it is going to affect not only the morale of the doctors, but the morale of the patients, the morale of the entire staff. I can tell you a lot of personal anecdotes also, which I won't.

But let me stay with this for a second. If you assume that the doctor is here for 2 days in West Haven, and on the average of what you are saying, somewhere between 2 and 3 years. Is it an administrative problem, a coordination problem, a scheduling problem—

Dr. **RASTEGAR**. The way it actually works is that—

Mr. **ROWLAND**. Are you calling the shots in this particular instance?

Dr. **RASTEGAR**. Yes. The way that actually works is that the residents and fellows are assigned to clinic one afternoon or two afternoons a week for a period of time. So that day, they spend one afternoon here, one afternoon at Yale. But they remain here for the whole year in outpatient.

It is inpatient that rotates, so that we should be able to provide a physician specific appointment for the patients. It actually works out that way in many circumstances. But if you ask me, are we meeting that goal completely, I would say no, we have not met that goal completely.

Mr. Rowland. What procedures are in place to accommodate matching a veteran up with a physician more than once in a row?

Dr. Rastegar. It depends on, again, which medical service. It would be varied from service to service. In medical service, they are assigned to a new physician at the beginning of the year. They remain with that physician as long as he is there. That's technically how it works out.

Dr. Genel. I might interject, without reference specifically to the VA, Mr. Rowland, this is a problem that is generic at academic health centers in general. We're aware of the problem. It's a problem of trying to arrange continuity of service by the same people over a period of time, and it's difficult when people are rotating. They're not always there.

It's not that it's not possible; of course it is.

Mr. Rowland. Let me make this argument. And being a lay person, I would assume that most of the veterans go to one particular clinic. How often—how long in the rotation cycle does a particular doctor stay within that clinic?

Dr. Rastegar. A minimum of 1 year, and a maximum of 3 to 4 years.

Mr. Rowland. I still am a little bit bewildered as to why we do not see at least some type of patient-physician relationships being built if most of the veterans are going to the same clinic. If there is a dietary problem, or a heart problem, you know, whatever the case may be, I think in these instances a veteran could see the same physician.

Dr. Rastegar. You're actually pointing out a major problem that is part of the VA system, which is that most patients go to many clinics. The goal of our plan is to limit them to only two, maximum three clinics, and use the other clinics for consultation only.

That, again, comes out of the history of the VA, which is the care was fragmented by specialty. What we're trying to do now is to focus the care, in a more general way, to a primary clinic, and allow them to use other clinics as consultation only.

Right now, most veterans do have a physician, and they know the physician and they see the same physician. But the care is fragmented into many—

Mr. Rowland. If you know any I would love to hear from them.

Dr. Rastegar. Well, maybe we're talking to different people.

Mr. Rowland. I bet we do. I won't debate that issue any more. I think you are getting the point, and I think it is going to have tremendous impact on everything that happens here. I think the patients and the doctors will be happier. I also think the morale will improve with the consolidation plan you heard talk of earlier, and having a whole new medical unit, clinical unit here. Do you foresee any particular problems in this planning stage that we are in now? Anything you would like to bring to our attention in these stages?

Dr. **Rastegar**. In regard to the clinic addition building?

Mr. **Rowland**. Yes. This consolidation idea of making West Haven more of a surgical unit and making Newington more of a geriatric long care facility.

Dr. **Rastegar**. In general, no. I think that would allow us to have appropriate base for a hospital with about 400 beds. Right now, I think that base has eroded. And if the number of patients who use this tertiary care increases, I feel we'll become much more efficient at providing care. So in that regard, I think it's very helpful to us. It's also helpful for Newington, because they will be specializing in a different area than we will be doing.

I think the communication between two centers would be the concern I would have. We have been working on that, as a matter of fact, over the last 3 months, and I hope that it will be an area which we will be proud of, and would not limit the quality of care. The communication between the two medical centers——

Mr. **Rowland**. Doctor?

Dr. **Charney**. I might add in terms of psychiatry, that the consolidation or consortium, however we want to put it, offers quite a number of possibilities in which West Haven would take care of acute psychiatry and Newington would take care of long-term issues in psychiatry. Right now we have a problem in that neither facility works optimally. We have many patients currently occupying acute beds, because we can't place them outside the hospital. Therefore we have difficulty meeting the needs of the community. I think the consolidation could be very helpful for psychiatric patients.

Mr. **Morrison**. It's okay, good question. I'd like to follow on John Rowland's question, Dr. Rastegar.

To what extent is there a primary care model that's been implemented for outpatient care at this facility, and what are the barriers to that kind of a model being implemented?

Dr. **Rastegar**. I think ideally the system that we would like to see would be that every patient has a primary care physician. And then other subspecialties are brought in as needed.

In reality, that is not the system in either private practice or at the university, the one that we think probably is a better system than we have right now.

At the present time, the primary medical care clinic takes care of about 2,000 veterans at any given time. But we have about 18,000 come to the hospital. The remainder of those patients are cared for in different clinics. Some of them don't even come to medical clinic.

But if you look at the population in the medical center, about a fourth of the patients have a primary internist involved with them. The other three-fourths are in subspecialty clinics: cardiology, kidney clinic, etc., and they get their primary care over there.

If you wanted all those patients to have an internist to give them primary care, an internist can see about 1,000 patients a year. That's the number they usually follow. Having about 3,000 visits a year. That's sort of the maximum number we work with. If you have about 8,000, 16,000 in your system, you're going to be talking about a very large number of primary internists who will need to just do that.

We have difficulty doing that, primarily because we also provide tertiary care, dialysis center, lab research, etc. We have other highly specialized areas that our patients actually need. We have a major geriatric commitment with about 7 physicians working in that area. All of those are commitments that we like to meet.

The plan that we have come up with is that each patient will have a primary physician, but it may not be a physician in the medical clinic. It may be in the cardiology clinic. But each physician will recognize—rather each patient will recognize one physician as their doctor that he can go to for a problem. The other clinics will be used as needed, depending on the nature of the disease. That's the plan that we are entering at this point.

Mr. **Morrison**. But in a sense, that's a compromise that you're talking about, where specialists and subspecialists are being used as primary care physicians because that at one point or another happens to be the kind of problem the patient is dealing with. Is that right?

Dr. **Rastegar**. That's correct. But fortunately in internal medicine, specialists are internists who have specialized. So they have to go back to the nature of what they are.

Mr. **Morrison**. Would the other approach be—it's just a question there aren't enough FTE's to have a number of internists to run it the other way, is that the bottom line?

Dr. **Rastegar**. That is correct. I can give you a number. I have 29 physicians in medicine. Twelve of them are committed to emergency room, which is a primary care area, and to geriatrics. Two are administrators. That leaves me with about 15 people taking care of 10 different sections in medicine, from all those specialized areas: cardiology, nephrology, diabetes, endocrinology, and so on. Each section has only one—occasionally half a person. The most is in cardiology, three and a half persons. So we're talking about an attempt to do everything in a tertiary care center: education, research, be promoted at Yale, take care of the patient. That takes a lot of creativity with the number that we have. I think the plan that we have is a compromise, but I think it is an improvement over what is there right now.

Mr. **Morrison**. The distinction with the Yale New Haven situation is that the majority of the patients would have a private primary care physician as their primary source of care, and then the subsequent referral to the tertiary hospital treatment?

Dr. **Rastegar**. But they have that in the community, not at Yale New Haven Hospital.

Mr. **Morrison**. Right, I understand.

Dr. **Rastegar**. The Department of Medicine at Yale sees the same number of people as we do at VA. We have a fourth of their staff, compared to Yale New Haven, departments, on full-time basis. However, those patients do not come to medicine for general internal medicine care. Mostly they only come for specialty care. We are trying to do both at the same time. We have to.

I've actually looked at many other hospitals around the country. This is a generic problem. All of us are groping with methodologies that would allow us to do all—meet all three goals of VA, which we all believe in. That's why we're here. At the same time, make sure that patients get the best care possible.

Mr. **Morrison**. You're basically an HMO without the HMO staff to compliment the tertiary care staff, isn't that what's doing it?

Dr. **Rastegar**. I believe to do tertiary care—

Mr. **Morrison**. Right. You've got the tertiary care, but you don't really have the staffing, even though you're called on to do the HMO kind of treatment. Is that right?

Dr. **Rastegar**. Exactly.

Mr. **Rowland**. Let me just pose, maybe not a question, but a thought. Dr. Genel in his personal vignette, I think, brought something up that is also translated to the veterans. And that is to go from one beautiful, wonderful facility, Yale, to West Haven, which of course, needs an awful lot of work, especially the surgical areas and medical facilities, that it became—I think your words were depressing and somewhat frustrating. And unfortunately, especially with some of the young doctors, that's translated.

So I would as a personal notation, encourage you in working with your staff to not transfer that frustration, if at all possible, on to the patient. And with the consolidation plan, I am very hopeful that the surgical unit and some of the facilities will be upgraded tremendously. And so I would ask you to keep your fingers crossed and be patient with us as we make some dramatic changes.

Doctor, you look like you want to make a comment.

Dr. **Genel**. Well, I can assure you, it's not a vignette that I repeat to our medical students.

Mr. **Rowland**. I appreciate it, because I think it's very true and it's human nature. I think we have to deal with that, and we just ask you to be patient and to continue doing a good job with our veterans.

Dr. **Genel**. Well, we thank you for all the effort that you have put in, and Mr. Morrison, as well. We're very appreciative of your efforts.

Mr. **Morrison**. Let me just in closing say that I certainly know on a personal level of the commitment of the Yale Medical School, of the individual physicians who are here today, and of Dean Rosenberg, as well as Dean Genel to this relationship. I think it's a very important one. This VA medical center can be what it can be only because of this affiliation, and we want to nurture that.

We understand that the circumstances under which you're being asked to work are far less than ideal, and I hope that we'll be able to do some things over the years to improve it. But you all know about budget deficits and the like. And we're really fighting a very, very difficult problem all the way around. I just think the important message is that we're all on the same side here, trying very hard to address them, all fighting a generalized enemy—in terms of the fiscal problems. I hope we'll continue to fight; and I certainly look forward to working with you in doing that.

Thank you for testifying.

Dr. **Genel**. Thank you very much.

Mr. **Morrison**. We now have an extensive list of representatives of the veterans community here in Connecticut, from whom we are going to hear. We have 16 separate witnesses scheduled to testify. We believe it's very important to hear from all of you, to hear the full range of perspectives and the like. I'm going to call you up in panels of four, and ask you to summarize your testimony. If you've prepared written testimony, that written testimony will be made a part of the hearing record. We look forward to your input.

The first four are Mr. John J. Grogan, Commander of the Department of Connecticut Veterans of Foreign Wars; Mr. Kevin Laydon, president of chapter 251, Vietnam Veterans of America; Mr. James J. Peters, executive director of the Eastern Paralyzed Veterans Association; and Mr. "Buck" Gillispie, a member of the board of directors of the Blinded American Veterans Foundation. If the four of you would please come forward.

Unfortunately, Mr. Kevin Laydon is not able to be with us today, although we earlier heard from another representative of chapter 251 of the Vietnam Veterans, and we certainly appreciated his testimony. So if the three of you—let's see, who don't we have yet? Is Mr. Grogan here? If not, we'll proceed with the two of you.

Mr. Peters.

STATEMENT OF JAMES J. PETERS, EXECUTIVE DIRECTOR, EASTERN PARALYZED VETERANS ASSOCIATION

Mr. Peters. Good afternoon, Mr. Chairman. I thank you for the opportunity you and Mr. Rowland have presented by holding your hearing here in Connecticut.

The Eastern Paralyzed Veterans Association met with you approximately a year ago here at this same VA station on a very happy occasion, to dedicate the Neuroscience Center, a combination of centers between Yale, VA and our organization, whereby we can advance medicine.

Over this past year, it has become more apparent to us as an organization that there are many things left to be done. In January of this year, the Eastern Paralyzed Veterans Association finally recognized that there has been a lack of faith or a loss of faith in some of the promises and things committed to us by our Congress, by our President, by our people. Therefore, we've brought suit against the Veterans' Administration, the Castle Point Veterans' Administration Hospital, and those people delivering care at that facility, with the idea in mind of pursuing quality care for veterans.

The issue of quality care has been talked about at this table during previous testimony, and many times, it comes back to the issue of money. More truly, it's an issue of respect, we feel. Somebody has lost that respect for the veteran that we feel should be renewed. The fact that a physician cannot schedule appointments for a veteran. It might be something so simple as a computer. We don't have it; we need it. The fact that a facility, the windows are falling out of. It's ridiculous. The fact that we contract out and buy back the services of the same man we laid off because we can't afford to have him as an employee, yet we can pay more to have him as a contract or service person.

We face the same problem throughout all of our geographic areas. Patients here in the Connecticut area must go to the Castle Point Veterans' Administration Medical Care Center for that care which specializes in spinal cord injury. We don't have the facilities, nor do we expect them, in every VA in the country. Yet where they do exist, we expect them to be good. They should be. We have the capability in the Veterans' Administration to provide it, yet we don't.

The lack of faith that I referred to before hopefully will not be resolved by the courts. It's not our idea or direction to have the courts resolve the problems that we cannot correct within the Veterans' Administration, its something that Congress can assist us in correcting.

The major veterans organizations have joined together to develop an independent budget, not to draw a pie in the sky of what fantasies could be drawn from everybody's idea of what we would like, but the reality of present day spending, what we really need to operate this system called the Department of Veterans Affairs now—and make it operate for the veteran. We feel that the budget as presented by the independent budget study should be the budget for the VA. All of the talk and the discussion about new programs should be those supplemental things.

But as a base discussion, we need to start remembering who that veteran is, and start respecting the veteran and providing the facilities for them.

Hopefully, our lawsuit will be resolved before the court has to make the decision as to how veterans will be provided for. And hopefully the Congress will help us and assist us in our plea to make veterans respected as they should be in our community.

Thank you for the opportunity to talk to you.

[The prepared statement of Mr. Peters appears on p. 102.]

Mr. MORRISON. Thank you, Mr. Peters.

Mr. Gillispie.

STATEMENT OF GEORGE "BUCK" GILLISPIE, MEMBER, BOARD OF DIRECTORS, BLINDED AMERICAN VETERANS FOUNDATION

Mr. GILLISPIE. Yes, thank you, Congressman.

I am a patient of primary care. This is just something I want to throw in. Since I've been on that program, I've had three doctors. I'm about to get their names straightened out, and then they're shipped off to some other station or something else. So I think this idea of having a doctor that you can kind of count on makes a lot of sense.

Now I'll get down to why I came here, to talk about the blind rehabilitation center in this building. Part of it's just around the corner here, and part of it's up on the fifth floor.

They have deteriorated so bad that they are giving and calling a person rehabilitated in mobility in some cases as little as six or eight classes. When this center started, we planned 60 mobility lessons and figured to get in a hundred in order to make a veteran safe to cross a street. And today I heard that "Well, why don't we cut back, so we can take care of the backlog." Well, it is a matter of time element. A man stays until he is considered safe to go out with the best he has to offer, whether it be because of his diabetes or some other ailment in addition to his blindness.

So this center has problems in recruiting staff because to put a man safe on the street, a mobility lesson has to be taught by somebody who knows what he's doing. I don't want to step out in front of some Mack truck if I'm not sure that I've analyzed the street corner. So we must be permitted to recruit staff to take care of the some 21 veterans they have.

We have now designed this center as a clinic and a blind rehabilitation. center. You've got veterans who wonder why they can't go bowling, others who are going bowling, and you've got them together, and they don't work together.

Now as a remedy, I mentioned in my written testimony to take 5 East and West upstairs here, which was promised to us. It was promised to us some 6 months ago, to go ahead and move the whole fifth floor, east and west, for blind rehabilitation, part clinic and part strict blind rehabilitation. And so I strongly urge that Mr. Browne and his staff go ahead and fulfill what they started to do and then permit us to recruit. Surely they've got authorization to recruit.

That leads me to another problem. I think administratively, they have slipped up there, and I think that has to be addressed. Two areas I mentioned in my testimony, or in my written part. There should be either training for staff, administrative staff, to do their job properly, or assign them to some other kind of work, if you want to keep them on.

We in blind rehabilitation are very concerned that there's no one being trained in the system for future administration. When I, as chief of blind rehab, I put it in and I got it right up to the edge of yes, we'll do it. And I don't know, some place up the way, it slipped. That is to take blind people, like they do for other departments, they make pretty good role models, and train them to be administrative staff. If we had ten of them in training, then our blind centers across the nations wouldn't be staffed by sighted personnel except for one.

And I think it's time that we take the original document that says a man by the name of Russ Williams, who was a blinded veteran out of World War II, would be the chief at Hines, which is the first center. It was stated in written form, the same as it was in prosthetic and sensory aids, that the major disability is important as a role model. And that had been carried out primarily through the prosthetic and sensory aids. But it was forgotten. And then the master's degree people coming out of blind rehabilitation schools for mobility and such looked on paper much better than those who are blind. And I think it's time we start training blind people to do the job that we know can be done and was done.

Now I can't understand why this place has slipped—this VA hospital has slipped so far down that they're lucky to have four clinic patients and 16 blind rehab patients and not enough staff to teach them.

So I went out to Hines. I was out there a couple of weeks ago. They are still running their 30 beds. They need help. But their staff, the loss has been much less than it is here. I can understand it. We fought cockroaches here, and I understand they're still having close order drill here. I can't understand why—I said I wasn't going to talk about that—I can't understand why we're dressing up the place outside and we haven't started on the place inside: windows, air conditioning, and that kind of thing. I'm wondering where the priorities are, and I hope they, in our case, come back to blind rehabilitation, and begin to look at us.

My first note up here says "regionalization." We're responsible for blinded veterans from Virginia clear through the tip of Maine. In those areas where they took this into full consideration, they seem to be doing the job. Sure, they've had troubles and are having troubles, and I'll address that, Mr. Rowland, in my next communication to you about what's needed in research and so forth.

One of my pet ideas for research that should be done by the VA, because we've got lots of people who need it, is how to direct electric wheelchairs through the new system of—call it what you want—so it can be set on a track. I'm not talking about going downtown to shop, although that might be possible, I don't know. The thing that is possible is that you can get to your bathroom by yourself, you can get to your dining area by yourself, you can go out on your sun porch by yourself. And with a little research, I'm sure that wheelchairs can be taught to do this.

I was down in Central Office. I said what's that? They said, that's the mailman. I said, who is the mailman? Oh, that's an electric cart that stops at everybody's door and beeps and they go out and get their mail. That's working. I'm not saying put a blind man in there to hand them the mail, but I am saying that some of that same system can be used. I've been preaching it from shore to shore, and I'm hoping it gets on with it.

I've got a half a dozen other things that I can put into writing, so I won't take more time today. But these are the major ones, right here, is to get that fifth floor started in to blind rehabilitation, and then when the time comes to remodel, ship it from east to west and west to east, it's going to be much easier. And keep our blind rehab intact, than moving them all over the place.

Start recruiting. I can show you what they asked me how to start recruiting. One is to put more money in the pot. Of course, we've had some of that, and I hope we get some more. But I also know that you go out here and sell the VA. Nobody in this country has ever sold it any better than I have, or tried to. I've been in the business since 1949 of blind rehabilitation, veteran style.

So I'll put the rest of it in my documents when I send them to you. I sure appreciate being here to sound off a little.

[The prepared statement of Mr. Gillispie appears on p. 112.]

Mr. **Morrison**. Thank you very much.

Mr. **Rowland**. Buck, just a quick question. You highlighted a few problems right along the line: communication, coordination, training, outreach. I see in your testimony you make reference to visiting a number of centers and I know you have. I think I join with many of the people here today in thanking you for tremendous advocacy.

In a nutshell, what do we really need to oversee the whole operation? I know that on an informal basis, you have been good about communicating problems at particular centers. We can throw more money at the problems, we have always talked about that. But in a nutshell, what would you suggest as a way to reach out to more blinded veterans out there? The independent living skills here at this facility are, I think, very good. I don't think enough people are taking advantage of them. What should we be doing?

Mr. **Gillispie**. Well, there are on the drawing board, there's two more centers that have been requested for by the regional medical center, one in Pennsylvania, I think, one in Texas. I don't know when they'll be coming out.

In the meantime, we've got to straighten up and recruit staff here and wherever else we need. We need to get into some research. Three million dollars was put into this synthetic speech machine, and now I've had in the past month, I've had six blinded veterans say they've had to wait over a year to get evaluated and be supplied. One of them was right here, a big argument between the region and Newington, and nothing was done. It laid on somebody's desk for 8 months. He works here in this blind center. Service-connected, hundred percent, computer equipment, and somebody sat on it.

Communications about blind rehabilitation and some knowledge, and notice—in my written statement I talk about the prosthetic and sensory aids. This has got to be straightened out, to give evaluation—and these centers should all have a so-called research—I'd still like to see it called research—but it's an evaluation on those aids. Now one veteran spent 8 months, the VA paid for it, went to another rehabilitation center, a civilian one, and they paid for it, bought the services. It should have been done right here, and equipment bought and paid for, rather than delay and wait and so forth.

What else can I tell you?

Mr. Rowland. One quick question for Mr. Peters. I see the EPVA has endorsed H.R. 1199 and H.R. 901. Any other provisions we should include in that as we go through the hearings and the markup this year?

Mr. Peters. The provisions we go back to, you know, all the things that we do put us in that same situation we've been in before. Each item that we ask for consideration of comes out of the master budget. So we take it out of the left pocket to put it in the right pocket. We're not really helping our whole system that way. We wind up, yes, getting a program passed by a particular piece of legislation, but it doesn't help us in the long run.

If I were to ask for those things necessary for only spinal cord injured veterans and were to get them, the system would hurt because we wouldn't be able to train and educate enough doctors in other fields. So it's the system in general that needs the help, not one specific program.

Mr. Rowland. Thank you.

Mr. Morrison. Thank you both for your testimony.

Mr. Gillispie. Here's one of those $3 million things that helps me to tell time. It costs—this sheet—$39.95, and it's not available in the VA, unless on special request. Thank you.

Mr. Morrison. You're welcome.

First our next four persons on our next panel are Col. David B. McQuillan, the commandant of the Connecticut Veterans Home and Hospital; Mr. Larry Salvaka, Commission, Department of Veterans Affairs, State of Connecticut; Lt. Col. Edward J. Giering, commander of the Connecticut Chapter of the American Ex-Prisoners of War; and Mr. Richard Perry, president, Concerned Veterans of Connecticut.

Colonel McQuillan. Good afternoon, Mr. Morrison.

Mr. Morrison. Good afternoon.

Colonel McQUILLAN. Mr. Rowland.

STATEMENT OF COLONEL DAVID B. MCQUILLAN, COMMANDANT, CONNECTICUT VETERANS HOME AND HOSPITAL

Colonel. McQUILLAN. Thank you very much for this opportunity to meet with you this afternoon and participate in your deliberations on the planned revised mission of the Federal Department of Veterans Affairs facilities in our State, and the impact that those revisions may have on the availability of health care services to the almost 400,000 veterans now living in the State of Connecticut.

My name is David McQuillan, and I am the Commandant of the Connecticut State Veterans Home and Hospital in Rocky Hill. I also serve as Vice President Region 1 of the National Association of State Veterans Homes, and am a member of their Congressional liaison committee.

The Connecticut State Veterans Home and Hospital has a proud tradition of providing services to veterans of this State. From its dedication on July 4, 1864, this agency has extended a helping hand to wartime veterans and their families over the past 125 years. Since 1888, our services have been supported by a partnership with the Federal Government, who shares with us the cooperative effort of delivering comprehensive and continuous health care to veterans of this State.

On our spacious grounds in Rocky Hill, the geographic center of this beautiful State, we operate a 350 bed joint commission accredited hospital and a 650 bed domicile funded through joint contributions from the veteran patients, the State of Connecticut, and the Federal Government. As a result of recent studies directed by our governor, we are now planning revisions to our mission that will insure the levels of care we offer meet the legitimate needs of our veteran population now and into the next century.

Traditionally, we have relied very heavily upon the two Federal Department of Veterans Affairs medical facilities in our State for referral of veteran patients whose condition exceeds our capability. Increasingly, we are turning to community hospitals for services no longer available from the Federal VA centers. We know that our supporting centers have extended themselves to accommodate the needs of our patients. But when their resources have been reduced by Central Office directive, they are compelled to focus on internal needs and our requirements, of necessity, become secondary.

In the highly competitive effort to fill vacancies for health care professionals, we and our friends in the VA find ourselves at a decided disadvantage and on an uneven playing field when compared to our colleagues in the private sector, whose flexibility and generous budgets enable them to offer salaries and working conditions far more attractive than those available within our organizations. As a result, we strive to do more with less, and consequently we drive away our good employees to private hospitals where staffing ratios and higher pay make for a much more rewarding and attractive employment package.

Again, my sincere thanks for this opportunity to testify today.

[The prepared statement of Colonel McQuillan appears on p. 124.]

Mr. Morrison. Colonel McQuillan, thank you very much.

Mr. Salvaka.

STATEMENT OF LARRY SALVAKA, COMMISSIONER, DEPARTMENT OF VETERANS AFFAIRS, STATE OF CONNECTICUT

Mr. Salvaka. Congressman Morrison, Congressman Rowland, thank you for this opportunity to appear before you as you assess the impact of budgetary constraints of the delivery of health care services to veterans in Connecticut.

My name is Larry Salvaka, and I am the Commissioner of the State Department of Veterans Affairs. My agency is a new one, having been established in 1987 and recently expanded as of July 1, 1988, to include the State Veterans Home and Hospital as an organic element of the department.

As the principle advocate of this State's veterans, I have a profound interest in insuring that their health needs are adequately addressed by the Federal Department of Veterans Affairs. As residents of the most affluent State in the union, our veterans tend to be self-sufficient in meeting their needs for housing, educational assistance, and medical treatment. As a result, we rank 50th among the States in per capita expenditures by the Federal Department of Veterans Affairs.

But for those among our more than 400,000 veterans for whom the Federal Department of Veterans Affairs facilities are the primary source of health care, any downgrading of available services can be catastrophic.

My department enjoys a close and cooperative working relationship with the Veterans' Administration Regional Office in Hartford and the two medical centers in the State. Through frequent formal meetings and regular ongoing discussions, we keep each other informed on matters affecting veterans in this State.

My plea to you today is that those channels of communication remain open as revisions are planned for the provision of health services to Connecticut veterans from Federal Department of Veterans Affairs facilities in this State.

Once again, thank you very much for including me in your hearing today.

Mr. Morrison. Thank you very much.

Colonel Giering.

STATEMENT OF LTC. EDWARD J. GIERING, COMMANDER, CONNECTICUT CHAPTER, AMERICAN EX-PRISONERS OF WAR

Colonel. Giering. Mr. Morrison, it's a great pleasure to come before the committee this afternoon.

As I said in my statement, I represent the American Ex-POW's in the State. We are certainly concerned about the reduction of the medical benefits available at the VA hospitals here.

Public Law 97–37 established a priority for POWs back in 1981, and quite recently that has been changed so we do not have the same priority any longer, as I understand it. There is a bill, H.R. 1780, which is in Congress now, which mandates for POWs outpatient treatment for the POW on the same basis as inpatient care.

All veterans have traditionally been guaranteed VA medical care. And the question many older veterans are asking now is why, when the World War II and Korean War veterans are retiring in large numbers, are the veterans medical benefits being curtailed?

Connecticut has the highest average income in the U.S. The income categories used by the VA, as Mr. Browne mentioned earlier, should not be the same here as, for instance, they are in some of our southern States. This does not seem to be equitable.

The priorities established by Congress in public law 97-37, as I said, have been changed, and we're looking for the POW priority to be reinstated because of the fact that many POWs, surprising as it may be, do not have a service-connected disability.

I shouldn't even bring this up, because it's not probably what you're looking into—but because of the fact that I deal so much with POW requests for compensations, we've become aware of the fact that the intent of Congress under Public Law 97-37, which was established many benefits, oine of which was what they call a POW protocol physical exam. The exam was to determine whether many of the POWs who had not been granted disabilities previously due to the fact of lack of medical documentation and so forth, were eligible. They would have an opportunity at this time to be examined physically and mentally and establish a new claim for compensation. It is apparent to me that some former POWs are having very poor success with this exam, and I think part of the reason is that the POW physicians at the hospitals who are appointed to examine them are not fully indoctrinated in POW type illnesses. As a result when the VA raters receive the results at Hartford, they don't see the medical documentation necessary to establish the disability compensation.

I think it would be of great benefit to the POWs in this State to see that both the rating people at the regional office and the physicians at this office are fully indoctrinated in the medical problems of the POWs in this area.

One of the things that POWs have lacked are medical records stating what their medical problems were while they were in the prison camps. They also have trouble obtaining records from the VA of treatment received since that time. And in pursuing this, I found that, for instance, at this facility here, we didn't seem to be able to go back very far, 1979 or 1980 in some cases, to find medical records, although it is known that the veteran has been coming here since, say, 1950.

It has come to my attention that recently a large amount of medical records were found here at the WHVA, and this is no fault of the present administration, they were probably put away long ago. When I inquired about this, I was told that they would like very much to get into those records and to see whether they contain some of the necessary records that we've been looking for, for some time now. But apparently, that required quite a bit of additional money for that purpose. And also you have to have people trained in medical records to go through them.

I hope that, although this is a very small matter, I hope that maybe the money can be made available to the VA here for that purpose.

Thank you very much.

[The prepared statement of Colonel Giering appears on p. 125.]

Mr. **Morrison**. Thank you, Colonel Giering.

Mr. Perry.

STATEMENT OF RICHARD PERRY, PRESIDENT, CONCERNED VETERANS OF CONNECTICUT

Mr. **Perry**. Thank you, Congressman Morrison and Congressman Rowland.

Years ago, a young fellow stood before the head of VA on Cedar Street in New Haven, Connecticut, and was told your health care needs will always be taken care of by a grateful nation. I find that now, 43 years later, the VA is not able to do this.

Over the years, through some mismanagement by previous administrations and a money crunch in Washington, the veteran is being let down. The hospital was rundown badly, but even as I speak, this is being turned around. The buildings are being remodeled, future new buildings are being considered, but we still have a long way to go to bring the medical center back to its rightful place in this world.

No one can deny that the staff of the West Haven facility is the most dedicated, loyal group of people I have ever encountered. But they are working under a terrible handicap; namely, outdated equipment, staff shortages, and so forth. We are losing more and more of our valuable employees to other hospitals and private industry because the VA medical center cannot compete salary wise in the job market. The money must be brought more competitive to entice the best there is into the facility.

Veterans in the B and C category are being put out of the hospital because they have been wise in planning their future. I am appalled at the idea that a man's status as a veteran depends on how much money he has. As President of the Concerned Veterans of Connecticut, I believe the means test is a very unjust piece of legislation. Fifteen thousand dollars in the State of Connecticut is a drop in the bucket compared to, say, the State of Mississippi. I believe the amount of money a veteran is allowed to make should be judged by the cost of living in the State in which he lives.

Also we do not object to the insurance companies, including Medicare, paying some of the tab, as long as the money goes to the veterans hospital who (sic) supplies the services. I'd like to repeat that. The money goes to the hospital, not to a fund in Washington.

In closing, I would like to say that the VA Medical Center needs more money so it can give the best medical services possible. As the saying goes, we are number 1 because of our veterans. Let's not let Washington overlook this.

Thank you.

[The prepared statement of Mr. Perry appears on p. 126.]

Mr. **Morrison**. Thank you very much.

Mr. Perry, I take it that first of all, you'd be very supportive, even if you might wish we didn't have an A, B, C category at all, that if we do have such a category, that we more realistically assess the cost of living in different parts of the country. Is that right?

Mr. **Perry**. Yes, sir, yes, sir, I do.

Mr. MORRISON. And there are proposals to deal with the way in which the private insurance assessments which are currently made are actually attributed to the hospitals where the collection takes place—or the services take place. That's in some legislation that Mr. Rowland has mentioned. And there are differing percentages. But I take it from your testimony you think that would be important?

Mr. PERRY. Absolutely.

Mr. MORRISON. And you propose that we go further and take—go to Medicaid as well?

Mr. PERRY. I do, sir.

Mr. MORRISON. Colonel McQuillan, I wonder whether you in your operation have experienced the kind of salary problems that are being discussed here in terms of your ability to attract qualified personnel?

Colonel MCQUILLAN. We're very competitive in the State in salaries. In fact, in starting salaries, we are better than the comparison that was recently done by—actually the union, H.R. 1199, did a salary—statewide salary in all hospitals, all 36. And we come out in the State of Connecticut extremely well. Where we're hurting in terms of compensation is in that shift differential you mentioned earlier: weekends, evenings and nights.

I had the occasion to spend too much time this year at the delivery end of the health care delivery system, or the recipient end, rather, as a patient. I was in too damn many hospitals in the State and I got to see it first hand. And I found that in virtually all the nurses that I dealt with, and there were so many, to see a ward in a hospital with so many nurses, it was really an eye opener to me. I'm used to stretching them thin. But in Yale New Haven where I was a patient, in St. Rafael's where I was a patient, in Hartford Hospital and St. Francis, all of them have these flexible programs such that the nurse who has a family comes to work for 12 hours on Saturday and 12 hours on Sunday. That's 24, as I count them, but she's paid for a 40 hour week. That's called the Baylor plan. By the way, I got my master's degree from Baylor in hospital administration. So that's a very forward thinking outfit, I think you will agree.

I can't do that, Bruce. I don't have the kind of flexibility. I have the State policies on personnel, and I can do—I try to do, to accommodate the needs of the married employee, the mother with children and the like, but my flexibility is very limited.

Now fortunately in the past 2 weeks, I've had five nursing staff RNs of varying levels leave some months ago and return in the past 10 days, being disappointed in these very exotic jobs with large insurance companies as one of those managers of care, you know, who calls and says what's your diagnosis, why are you in the hospital, and what was your last urine test. They find that that's not satisfying to talk over the phone and bicker whether that patient needs another 3 hours in the hospital or can go home. They like being at the bedside, and thank God, they're reacting and coming back to us.

One of those, one returnee, is an overwhelming message to the others on staff. You know, as you lose people for good or—or nonvalid reason, whatever their cause, you're then short staffing the remainder, people who stay back, and they pay the price, you know? And after a while, people begin to panic and they say, I want to get out while the getting's good.

But to answer your question, you'll find that in the State of Connecticut—by the way, we compete like the VA does. I had a lady come to us to be interviewed for a supervisor's job. She was a staff nurse in corrections. Her salary—she paid taxes last year as a staff nurse in corrections, State of Connecticut, on $58,000. Our supervisor's job didn't come close to that. But you see, in corrections, there's hazardous duty pay. In mental health there's a special compensation that I can't offer, because our guys are not assaultive, so we tell them.

Mr. Morrison. Thank you very much. Mr. Rowland, any questions?

Mr. Rowland. David, I'd like to pose a question to you and I would like everybody on the panel to answer. You have all evaluated and heard about the consolidation plan. Again, I still hesitate to use that word, because we are really not consolidating services, we are trying to take the veterans dollar coming from Washington and make best use of it. Rather than trying to do surgical care at both facilities or long-term care at both facilities, let's specialize in one and make it the best possible.

Dave, from your standpoint as a State home administrator, what snags or problems do you see? And then I would love to get a feedback from you three also as to any potential problems or conflicts, or glitches that you see coming down the path in these next few years.

Colonel McQuillan. What I've learned of the plan, and I've been brought in on most of it from both of the directors, it makes eminent good sense to maximize your limited resources in personnel, equipment, facilities, funding. When I meet with my fellow commandants as we do often, and their people are travelling a day-and-a-half in Texas, you know, to get from one to another VA center, I count my blessings with the proximity of these centers. And I think it's kind of ridiculous in today's environment to try to be all things to all people. You know today, when you go to that eye doctor, he's either a left eye doctor or a right eye doctor, and he's going to ask you which one is having the problem. It's gotten so specialized and so highly technical.

We offer a very unique service in the State home of long-term care. You know, the average length of stay in this hospital is 7 days. My average length of stay exceeds 7 years. I have some who have been with me over 40 years in the same bed, the same ward. Now that's kind of depressing, but on the other hand, the alternative is more so if we weren't there to reach out and to help that veteran.

The only problem is that, you know, the needs for health care are sort of a bottomless abyss. With each technological advance, you've got to provide that new gadget to everybody equally and that ain't going to work. And the plea that the commissioner and I made to you today, and I hope we underlined it, is whatever you do, however you restructure the delivery of services, include us.

My census today exceeds the census of both Newington and West Haven, and yet you tend to forget about us. The patient who is being discharged from the community hospital quicker and sicker can't go to the nursing home, certainly can't go to his own home. He needs the kind of thing called chronic disease, which we've offered for 125 years, and which most community hospitals are now converting wards to accommodate the thing called chronic disease.

You know, Connecticut and Rhode Island, as far as I know, are the only two States who license that level of care. It differs from a nursing home because you have to have all the ancillary services: X-ray, lab, pharmacy, that no nursing home is required to have. And the physician must visit almost daily, as opposed to once every month. Those two differences make for the chronic disease hospital, which I am hoping our State legislature will see the wisdom of continuing in Rocky Hill.

But how nicely we dovetail with these other two facilities. You've got the Boeing 747 here, you've got a Piper Cub in Newington, and I've got the bicycle. But there are times when a bicycle is damned nice to have, like on Nantucket. So if we can get those kinds of levels of care ironed out, who is going to have what piece of the action, you've got no problem with cooperation, believe me. I know from what I hear from others that is a problem in other parts of our country, but not here in Connecticut. We're blessed with very cooperative efforts. They can only do so much, though.

Mr. SALVAKA. I'm in total agreement with that. Dave and I, of course, meet daily, and we also have a regular committee at the home and hospital. We discuss these points. And I think we are all in agreement that as long as we don't lose them outright, we're pretty well satisfied.

Ed can probably talk on it better. He is one of my service officers in the State of Connecticut. Possibly, it would affect him more than it would us.

Colonel GIERING. I'll just say that it sounds very rosy, too rosy; it may not turn out that way. Personally, I wouldn't want to have to drive all the way to Newington, then wait for a bus to come down here. Appointments are often very late. You may not even have the appointment after you get here. Then you have to get back on the bus, go back to Newington, then drive home again. I don't think that's a very good route. I'm sorry I have to disagree with the other people on the panel.

The other thing is that Newington lost part of its mission there—quite a few things, as a matter of fact, they lost the surgery and psychological care, etc., we had been told at that time that they were going to start a 26 bed long-term nursing home. But Mr. Davenport, in a meeting we had a week or so ago said that that's not in the cards anymore. Congress apparently, or the VA, someone up there decided that we're not going to have long-term nursing care in the State. And that looked like one thing that was really worthwhile losing a mission for.

Mr. ROWLAND. Did you say long-term health care—long-term nursing care at Newington?

Colonel GIERING. In the last year or two about that, they were talking about the fact that they were going to try and start, I believe it was 26 beds—

Mr. ROWLAND. Oh, that we would?

Colonel **Giering**. Yes. Initially. And then they would extend it, that was just going to be a start. But that was talked about for a year to compensate for the loss of their other missions. But apparently, that's not in the cards now. That's down the drain.

Mr. **Rowland**. Mr. Perry.

Mr. **Perry**. Most of my group are in favor of nursing long-term care, no matter where it is, as long as they're kept. If it's more convenient and more economical to group it this way, we're all in favor of that. We just don't like to see long-term patients put out to go in nursing homes and things of that nature when they've been here for a good many years.

Mr. **Morrison**. Thank all four of you very much for coming. Thank you for staying for a long afternoon, also.

The next four witnesses will be Mr. Edward Lettick, the Commander of the Connecticut Chapter, Jewish War Veterans of the USA; Mr. Edward Bogus, Jr., Commander of the Connecticut Polish American Veterans; Major Linda Schwartz, USAF (Ret.) Member Chapter 270, Vietnam Veterans of America and member of the Board of Director, American Nurses Association; and Mr. D. Joseph Jackson, Commander, Department of Connecticut, The American Legion.

Mr. **Pomfret**. I'm taking the place of Joe Jackson.

Mr. **Morrison**. All right.

Mr. **Pomfret**. He couldn't make it today.

Mr. **Morrison**. All right. You're William Pomfret, right? All right. Make sure that—you're going to be second, so make sure for the purposes of the record that you introduce yourself.

Ms. Schwartz, thank you for being here.

Major **Schwartz**. Let me just be clear that I'm here to give the statement of the State Council of Vietnam Veterans of America. I also have the honor of serving on the Board of Directors of the American Nurses Association, but today I'm here with the honor of being a Vietnam veteran.

I will ask you—what happened was after reading testimony that I made copies of, I realized that I had made some typographical errors, so I have a corrected copy for the record.

Mr. **Morrison**. We'll take that for the record and make sure that it is the corrected copy that goes in the record.

Major **Schwartz**. Thank you.

Mr. **Morrison**. The staff will be sure to do that.

STATEMENT OF MAJ. LINDA SCHWARTZ, USAF (RET.), MEMBER, CHAPTER 270, VIETNAM VETERANS OF AMERICA, MEMBER, BOARD OF DIRECTORS, AMERICAN NURSES ASSOCIATION

Major **Schwartz**. I just want to make some comments about some of the things that have been going on. And as one of the few nurses that have made it to the table today, I'd like to say that in my looking at the problem of retention and recruitment in the VA system, I looked at the recent President's Commission on the nursing shortage.

One of the things that was striking was the fact that the VA was experiencing a shortage long before the national shortage occurred. In 1984, the VA did a study. And again in the study that came from the Department of Health and Human Services, VA nurses pointed out reasons why it was difficult for them to stay. The number one thing that has been addressed here a couple of times today, in both from the physician's viewpoint and from the ancillary help, is the pay. I think the idea, the notion of the regionalization of that pay so there would be some latitude is very important. Because I just learned myself that a new graduate from St. Joseph's is going to be hired by a hospital, and this new graduate will be earning $42,000 a year. And it's at an entry level postion—it's enough to make you want to go into nursing, isn't it? You've got to be competitive here at the VA, and they have to have that at the entry level positions as well.

One of the things that also is a concern is the fact that when you do raise pay, that takes some shuffling of funds within the VA, because you've got a fixed ceiling. I served on the Connecticut Governor's Commission on the Medical Effectiveness of the Prospective Payment System, and we had to bite the bullet on that and give a pass through for nursing wages. I think that's something that Congress is going to have to look at, too. The salaries of people are going to go up, and as long as you've got that ceiling, you're going to have to rob Peter to pay Paul. What we're hearing and what we're seeing across the country, in some places supplies are not being refurbished and patients are having to suffer because of that shuffling of the funds.

The other thing that I wanted to say is—and I just this morning read an article which suggested that the VA is an excellent place to use what they call physician extenders, to use nurse practitioner clinical nurse specialists, because they are found to be more client friendly and this might be a way in which you could look at filling the gap of the physician.

Of course, the other part of that, and I have to be realistic, is that they are projecting that there's going to be a physician glut, so it's a wonderful time for the VA to really look at that and see if you can't cultivate physicians returning to the VA because they're going to be looking for jobs on the outside.

The other thing that I wanted to say is that problems in the work place have been well described today, and I won't belabor that point. But Vietnam Veterans of America feels that recruitment and retention is only one part of the problem. You have to have a good place to work, that's a major means in which you will get people to come and stay with an ongoing action.

I'm not sure that they have a recruitment and retention program in the VA, because we've been told about nurses in certain places who were so stressed out because of the lack of filling their positions that they took it upon themselves to hold recruitment teas to try to get people to come and join the staff of VA hospitals.

The other thing that I wanted to say just in the question about the means test that has been raised here today. The way in which that's structured, veterans are going to have to look to the VA more for care than they are from the Medicaid route because the means test is lower for Medicaid. You have to have less money in order to qualify for that than you do even with the VA. But it's a point to really consider, the difference of where $16,000 in this State will go and where it will go in other places.

And finally, the one thing that I wanted to say when you talk about long-term care, Connecticut has one of the best programs in the U.S. called Connecticut Community Care in which the patient is helped to stay in the home. And the services which they are required to have are first of all, assessed by a nurse, and then the contractual agreements are with those facilities, agencies to provide that care. In addition, the nurses go in and make sure that that care is being delivered before the bills are paid. I see that that is one of the most progressive things in the U.S. It's certainly something that this State can be very proud of, and might be something that could be looked into as far as VA funding for that kind of program.

One of the things that I have to say in closing is that all of the things that have been discussed here today I would like both of you to consider the need to really take a look now, at this time with the current crisis in health care in the U.S., to take a real good look at the VA system and see if we can't make it more efficient and more effective. Because Vietnam Veterans of America believe, and so do I, that there are numerous ways in which this system can be improved to provide better services for all veterans, now and forever.

Thank you.

[The prepared statement of Major Schwartz appears on p. 127.]

Mr. Morrison. Thank you very much. Mr. Pomfret, introduce yourself and who you're substituting for, and then give your statement, please.

STATEMENT OF BILL POMFRET, THE AMERICAN LEGION

Mr. Pomfret. Thank you, Congressman Morrison and Congressman Rowland. I'm pleased to be here.

My name is Bill Pomfret. I'm substituting for the Commander of The American Legion, Joe Jackson. I am the former administrator of the Connecticut Soldiers, Sailors Marine Fund. Over the years, I've had a lot of association with the needs of veterans in Connecticut.

First of all, I'll just mention that The American Legion Department of Connecticut does appreciate this opportunity to present its views on the medical needs of Connecticut veterans. Many of the problems that face veterans today are not new problems. They have been around for the past 8, 10, 12 years. We do not seem to overcome any problems, though we do have a way of adding to our problems. The American Legion would like to point out the three major needs or problems that we feel faces Connecticut veterans today.

One has certainly been aired this afternoon, and I'm going to be, probably, in repetition to some of it, that is the inability of our medical centers to hire competent, qualified staff personnel to provide service and treatment to veterans. Because Connecticut has the highest income per capita in the nation, the setting of wage schedules on a national basis may eliminate a hiring problem from many areas in the country, but it hampers the ability of the Connecticut VA medical centers to attract and pay for a quality staff, both professional and non-professional. Who suffers? The veterans of Connecticut. The American Legion feels very strongly that the VA wage schedule should be established according to the economic conditions of the areas of the nation. Regional wage structures are necessary if the VA medical centers in Connecticut are going to be able to compete in a labor market that is so competitive.

Another major concern of The American Legion is the lack of nursing home care, long-term care. I heard some rosy things this afternoon, but let me ask one question. Have you ever tried to get someone into a long-term care facility in the last 3, 5, 6, 7 years? You go on a list, and who knows where that list goes to. It is really so necessary for us to address this particular problem.

Fifteen years ago, The Legion completed a study on the future needs of Connecticut veterans. It was found that the number one problem was the care of the aging veteran The need for facilities to provide long-term care was paramount. Believe it or not, the need for sufficient facilities to provide long-term care for aging veterans is still our number one problem. We have added to that in the last few years the homeless veteran, so now we have two problems.

Even though we knew 15 years ago that long-term care would be required by the biggest pool of veterans, World War II veterans, little or nothing has been done to prepare for this need.

Recently I was in Washington and listened to the very ambitious plans of the VA to build a number of new medical centers. This is fine. However, perhaps a review of the spending should be made. Perhaps we should be looking at the staffing of facilities that we have. Some of the new facilities that were built, Milwaukee for one, are still not open because it doesn't have the staffing or the money to acquire it.

We should be looking into building long-term care facilities rather than invest money in projects that will not enable for us to take care of our first problem, and that is, caring for the veteran today.

In addition, updating our present facilities and providing modern equipment must be addressed. Otherwise, second rate care will be provided to our veterans. This should never happen.

Finally, again we kicked it around a little bit this afternoon, but The American Legion from, the beginning, strongly opposed the imposition of the means test and the third party payment. Let's provide medical care to all our veterans, as it should be, as it was promised by the Nation many years ago. No one asked the veteran how much money he had, or how much he earned, when they asked him to serve his country. We ought to think about this. And my suggestion and The American Legion's suggestion is do away with it. It's costly in administrating it, and I don't think you have saved a penny.

I want to thank you very much for your attention and for all that you both have done for the veterans of this country. Thank you very much.

[The prepared statement of Mr. Pomfret appears on p. 142.]

Mr. MORRISON. Thank you, Mr. Pomfret. The American Legion supported a regional wage approach to this. Is this a national position or a Connecticut position?

Mr. POMFRET. I think it's a Connecticut position, although it has been talked about nationally. I don't think a final opinion has come from the national headquarters, but they favor this particular type of approach, and I think it will come eventually.

Mr. MORRISON. Okay, thank you.

Mr. ROWLAND. I would just ask the same question I posed to some of the other panels. Your comments on the plans to have more efficient services at Newington and West Haven.

Major SCHWARTZ. Well, I come from east of the river, over there.

Mr. ROWLAND. We won't forget about you; don't worry.

Major SCHWARTZ. I think that we are concerned about the transportation, period. And the problems that we even now have in getting to Newington. Just last week, we had a veteran who started hemorrhaging and we couldn't find anybody to take him, so someone put him in his car and drove him to Newington. That's where he's a patient now.

There's no real direct public transportation, and I think that would be something that would need to be considered in the consolidation. For us to come to Newington or to West Haven will be—even now, it's difficult.

Mr. ROWLAND. Just to add a note, there is a transportation plan for the two hospitals. And emergency services would still be provided at Newington, even with this so called consolidation.

But we would love to get some input along the way as to what problems may occur, especially from those of you that are east of the river.

Major SCHWARTZ. Well, you know, some of us—to have a car, that's something that we all consider to be like having to have a doorbell or a telephone. But a lot of people don't have them. And when you were talking about homeless veterans, my practice in nursing was as a public health nurse. And I can tell you that I've seen veterans live in cardboard boxes in the woods. For them to get anyplace is a problem

Mr. MORRISON. That problem exists whether it's Newington or West Haven, either or both. Those are fundamental problems that have to be address on a whole other level.

Major SCHWARTZ. Now that you're addressing this other problem, maybe you would think of that, as well.

Mr. MORRISON. We're trying. You heard the long list today. We've got no terms—we're going to pass a hat at the end of the hearing; I hope people are still here.

Major SCHWARTZ. It's like being able to talk to Santa Clause, I realize.

Mr. MORRISON. Bill, did you want to add a comment?

Mr. POMFRET. No. The only thing I wanted to add is that I was substituting this afternoon. I'll have to mail you my statement, if that's all right.

Mr. MORRISON. Your statement, if you'd like to put it in in the form that you have it—

Mr. POMFRET. If you can read it.

Mr. MORRISON. Well, you read from it beautifully so your handwriting must be a lot better than mine. We'll be happy to have that.

We want to thank you for your testimony; also for taking the time to be here all afternoon. We appreciate that.

Major **Schwartz**. Thank you for your time.

Mr. **Pomfret**. Thank you very much.

Mr. **Morrison**. Our final four witnesses will be Mr. Nicholas Gentile, Commander of the Department of Connecticut Military Order of the Purple Heart.

Mr. William Stockholm, National Service Officer of Disabled American Veterans; Mr. Charles A. Kelly, Commander, Department of Connecticut AMVETS; and Mr. James Sparrow, Director, Agent Orange Victims, Vietnam Veterans of America. I don't think he's here.

About 50 percent here.

Thank you very much for being here. Your written statements will be made a part of the record. If you would, please, summarize for us.

STATEMENT OF NICHOLAS GENTILE, COMMANDER, MILITARY ORDER OF THE PURPLE HEART, DEPARTMENT OF CONNECTICUT

Mr. **Gentile**. My name is Nick Gentile. I'm the Commander of Purple Heart for the State of Connecticut.

Chairman Rowland and Chairman Morrison and Congressman Rowland, thank you for your invitation to speak today. Since this is a month when we traditionally honor our war dead, may I begin with a moment of silence to remember our missing in action.

Thank you. We are all aware of the spirit of Americans who put aside their lives and volunteer to serve their country. Those who felt secure in the knowledge—in knowing that their wounds would be healed by a grateful government with compassion and understanding. They were right, because our Congress and citizens alike put together a medical team second to none in the Veterans' Administration. Since that time, over the last 5 or 6 years, our national budget has gone down. At one time, it was about 5 percent of the national budget. I believe today it's less than 2.5 percent. I believe if we get that budget at 5 percent, I don't think we would have these problems we have today.

It seems that we forgot the veterans and we're going overseas and putting money overseas. I believe that's a wrong road to take. Charity begins at home, and I believe our budget should be brought up to 5 percent. I believe a lot of these things would take care of themselves in the coming years.

Mr. **Morrison**. Thank you very much.

Mr. Stockell.

STATEMENT OF WILLIAM STOCKELL, DEPARTMENT OF CONNECTICUT, DISABLED AMERICAN VETERANS

Mr. **Stockell**. Thank you, Congressman. I think that we've both worked together, so we don't have to deal with too much formality.

We're not as happy as everybody else is with the consolidation. We've been talking about these problems for the past 15 years. The State commander has submitted some comments from Ella Grasso who had the same type of hearing 15 years ago. We're talking about the same subject; we're talking about the same problems. Now it's a question of what kind of solutions are we looking at.

At that time, we were talking about turning Newington into a nursing home and building another facility out at the Farmington Medical Center. And we were told for years and years and years that Newington is antiquated, we cannot use it for geriatric care. Now what's happening, we're turning it into long-term nursing home care. So it's kind of hard for us to understand where for the past 15 years they're saying no, we can't do it. And now all of a sudden we are.

We were looking at, for the past year or two, the possibility of both hospitals going down the tubes. And, in our discussions with the hospital directors, we have basically come to the conclusion that we're looking for quality health care in the State of Connecticut. If it's going to come through the terms of consolidation, then that's the way we ought to go.

But now we're looking at opening Pandora's box here. We're talking about a new mode of VA medical treatment. It's called bussing. It didn't work to help integrate the schools, and I don't see how it's going to help us here. We're dealing with a situation—I'll give you an example. We have patients here at West Haven who require chemotherapy. We're throwing them in a bus and taking them to the Bronx. You're talking about 1½ to 2 hour drive, depending on traffic. And depending on whether they're going to get through the Bronx. Now when you're talking about chemotherapy type patients, you're talking about adverse effects, nausea, vomiting, things like this. What's going to happen on the way back? We're going to have medical problems we're going to be dealing with. And then what do we do, if we have a person who is in medical need, an emergency, is the driver going to be an EMT? Are we going to have to stop at Stamford, Greenwich or someplace along the road and stick him into a private hospital, and who is going to take care of the bill? We're going to be dealing with court claims, we're going to be dealing with 351 claims, we're going to be dealing with a mess.

So I think there are some areas in this consolidation that we really have to look at. About a month ago, the State of Connecticut didn't have any orthopedic outpatient clinics. We're going to bus everybody to Providence. This isn't making us happy at all. We have to have some coordination here. We don't mind consolidating the two medical centers into one center, if you want to call it one center with a 34 mile radius, one center. But we want to keep all services in the State of Connecticut. If we need chemotherapy, let's do something here. Let's deal with it on a contract basis, or let's deal with it with one of our medical centers that we're affiliated with. But let's do it here. Let's not bus these people 2 hours down and 2 hours back. It's just an untenable situation. We definitely don't feel that that's the way to go with that particular subject.

We're looking at now some problems with retention. We're talking to some of the medical directors here of the two centers. In Newington, they're talking about an authorized 153 nursing. And out of 153, they have 42 vacancies. We're talking about a fiscal officer that Newington was looking for for 20 months. So we're definitely in favor of this regional flexibility in salary structures. We think that that's the way to go with this.

We also are in agreement with the primary care. It's unfortunate that we can't get the medical staffing to make it work, but this would be the way to go with this particular subject.

We're also concerned about the means test. And we agree with The Legion that maybe we shouldn't have it at all, but if we're going to have it, I think that we should also look at the flexibility, in terms of the State of Connecticut. Maybe the means test isn't low enough for us.

Another question I think I'm going to direct to you two is this $30 million supplemental budgetary money that we may receive, okay. Let's say we receive it; where is it going to go? That's the big question. We have some serious needs here in the State of Connecticut. Even though it's going to be supplemental money dumped into the VA budget, who makes that determination of where that money is ultimately going to go? Where are the priorities set? Where does the State of Connecticut sit in those priorities? We've been the low man on the totem pole for a number of years. And I think that through our delegation, we've sort of gotten a commitment. I think they have a statement here that everybody has signed, saying that we sort of have a commitment to make sure that Connecticut gets its just due. Maybe it is the time that we should be seriously looking at that.

I think by implementing some of these particular subjects that we were talking about today, we might be able to do it. We have developed our own transportation program throughout the country, the Disabled American Veterans organization. We've taken it upon ourself when they first took the money out of the pot for transportation, we came up with our own money and we started providing volunteer drivers and also providing vans for the hospitals. And that program has been working out fairly well, but we still need volunteers and so forth.

So with any of these subjects, we would greatly appreciate you taking them back. In my formal paper, I basically talked about several areas that we are mainly concerned with which I just alluded to.

One other thing that I think we should seriously look at is what now is the mission of the VA health care delivery system? Is it the same as it was in 1945? Is it the same as it was in 1950? What are the needs today? Maybe we should be taking a closer look at what those particular needs are with the aging veteran, the homeless veteran, all these new issues that we've never really dealt with before. And determine what that mission is, the current mission, and make sure we have it funded so that mission can be accomplished. We all see the plaques in the halls that the VA medical system treatment is second to none. I don't know if we can say that that is true anymore. It's an unfortunate situation, but I don't think that we can say that. It's not the best medical care that's available. And it's something that we seriously have to look at. Whether it's consolidation, getting more money, what is the responsibility, you know, of Congress and the administration to the disabled vets and to veterans in general. What is that responsibility? Has it worn out over the past 20, 30 years? Let's take a close look at that, evaluate it, and do what's right.

Thank you very much for your time and attention.

[The prepared statement of Mr. Stockell appears on p. 132.]

Mr. MORRISON. Thank you. Mr. Stockell, let me just ask you. You made a comment about—your closing comment which in many ways summarized some of your earlier comments about identifying the mission and funding it adequately. One of the ways in which the Congress did that was through the means test and the definition of classes of care, or classes of veterans it would be focused on. Any statement about identifying a mission suggests drawing lines, you decide you can do certain things and you can't do certain other things. Do you think there are such lines that can be drawn, and if so, what kind of lines are they?

Mr. STOCKELL. I think there is a line that we can draw. Maybe sometimes we don't like to draw lines, but what was the system set up for, and is that system the same system, and whether or not that mission is the same mission. Originally these hospitals were set up to take care of the needs of the service-connected veterans coming back from war. And we had a few of them. We had a few of them after World War I, a few of them after World War II, and a few of them after Korea and Vietnam. Now the question is whether or not we're looking at the same problem.

We have gone from a 90 percent casualty treatment rate to like 25 percent. Seventy-five percent of the patients being treated in the VA medical system are for non-service-connected disabilities. So are we, in fact, really looking at that?

We have talked about the possibility of eliminating the VA hospitals totally and get out our little credit cards and give them to disabled vets and say okay, here, you go to a hospital, take care of the treatment, send us the bill. I mean, how much less is it going to cost us? A lot less. But what are we going to lose? We're losing a unique system, a system that's not only there to treat veterans, but it's also there to train physicians. If you take a look at how many physicians have gone through this system, a large percentage—a majority, 90 percent or more—have gone through this system. What have we developed in terms of medical procedures, treatment procedures, prosthetic devices, all of this has benefited not only the veteran population but the general population.

So we firmly believe that we should keep the VA medical system. But let's just set these lines. You asked me a question, what are the lines? Well, okay, we want to take care of the disabled vets. Alright, there you have priorities. Now we want to take a look at veterans that are in need, that don't have medical capabilities of going to the outside and having someone pay for it. We're also looking at homeless veterans. We're looking for treatment, we're looking for rehabilitation and so forth. The same thing with PTSD and Agent Orange. We have all these categories that we can lump them; if you want to call them A, B or C, that's fine. We have no problem with that. But let's just define it. We don't have problems with the definitions. I don't think so.

Mr. MORRISON. Thank you.

Mr. ROWLAND. I throw onto your list two other questions. We are talking about the big picture and dealing with some of the long-term problems we face. And I want to make a few comments about your going back to Ella Grasso and some of the same ideas that are coming up now that are a little bit different. But I pose two questions right now. One is are you happy with the surgical facilities that we have at Newington and West Haven right now, and the lack of long-term health care facilities?

Mr. **Stockell**. The answer to both is no. We're not satisfied.

Mr. **Rowland**. The answer is a definite "no"?

Mr. **Stockell**. Definite no.

Mr. **Rowland**. Anybody that uses the service knows it is a definite no. So with that, and also with the reality—I think that's what we're dealing with now—the reality of a lack of dollars. We are not going to wake up tomorrow morning and bring in millions and millions of dollars to build a new surgical unit, and millions and millions of dollars to do nursing beds, and millions and millions of dollars to bring up these two facilities to a level where they should be. I think we have come a long way in the last 6 months.

Mr. **Stockell**. There's no question about that. And we can take a look at some of the monies that have been set aside. We're talking about the $58 million facility that's being set aside for Newington, taking a $12 million surgical suite out of it and using that $12 million for something down here.

Mr. **Rowland**. That is what we are doing.

Mr. **Stockell**. Right, exactly, that's what I'm saying. You know, we are looking—

Mr. **Rowland**. That is exactly what we are doing in the consolidation.

Mr. **Stockell**. Right.

Mr. **Rowland**. Consolidation that there—

Mr. **Stockell**. We have no problem with the consolidation, as long as Connecticut veterans get their due. We don't want Connecticut veterans having to be bussed to the Bronx, bussed to Providence and so forth.

Mr. **Rowland**. Let me respond to the bussing reference, since I used it earlier in my remarks. The bussing is between Newington and West Haven.

Mr. **Stockell**. Also other facilities.

Mr. **Rowland**. Well, the idea of bringing veterans from 34 miles away—

Mr. **Stockell**. Also other facilities right now, it's happening right now.

Mr. **Rowland**. For what services?

Mr. **Stockell**. We're talking about chemotherapy, we're talking about services that are being bussed to Providence. We were talking about at one time closing both outpatient—orthopedic outpatient clinics. Give me a break. Closing both—having no orthopedic outpatient clinics in the State of Connecticut. Now is that ridiculous or what?

Mr. **Rowland**. Where were they getting chemotheraphy 3 years ago?

Mr. **Stockell**. Good question.

Mr. **Rowland**. Two years ago?

Mr. **Stockell**. Good question.

Unidentified voice in the background. Yale New Haven.

Mr. STOCKELL. Yale, basically.

Mr. ROWLAND. Why can't they go to Yale today?

Mr. STOCKELL. We're talking about dollars; we're talking about dollars. We're going to—you're going to have to pay for that chemotherapy out of one of the pots.

Mr. ROWLAND. And how do we pay for the chemotherapy going down to the Bronx? It's in the VA system?

Mr. STOCKELL. It's in the VA system. So the only thing that we have to pay for is the transportation back and forth. Now who is the one who's got to suffer for this?

Mr. ROWLAND. The only other question I bring up, and I want to get more feedback. I think Bruce and I both want to get more feedback on the consolidation ideas, but it's not the same as back in the late 1960s when we talked about building a whole new system at Farmington. That has been talked about for 25 years—

Mr. STOCKELL. Right, since 1968. We know what that scenario is all about. We have to deal with the facts of life, just like everybody else. I don't think that we're trying to be unreasonable. Basically what we're saying is, you take a look at Texas. What kind of medical facilities do they have? We're looking at some of the other strong Congressional staffs. What kind of facilities do they have in those places? Now we're talking about Connecticut. How many tax dollars do we put back into the Federal Government, so how much money is coming back here to take care of our vets? What we're saying is give us our due. We're paying the taxes, give us our due, so we can provide the services here in the State of Connecticut for our veterans.

Mr. MORRISON. I think you make a good point, and I think that what you've seen—I hope what you've seen, especially in the last year or so, is an attempt to marshall the Connecticut delegation to that mission, and also to make prudent use of the resources we have. Because we're in danger of having two facilities that could not be supported. And at that point, you'd start to lose everything.

And we've lost some things, and you're correct about that. And the hope is by rebuilding this facility as the primary hospital in terms of tertiary care and increasing the capacity of Newington in the area of long-term and geriatric care, that we'll have two first class institutions rather than two second class dying institutions. It won't be perfect, but I think getting behind that process gives us a better chance of working as a statewide unit. And be able to pay for it, right. So I think your points are well taken.

Mr. STOCKELL. We're all on the right track, and as long as we continue in that, we should be all right. Thank you very much.

Mr. MORRISON. We want to thank both of you, and we want to thank, in addition to those who did testify, we want to thank those of you who came and listened to this testimony. You may have ideas of your own that you didn't hear expressed up here. Either John or I or both of us are always happy to receive mail. And please drop us a line if there's a point you didn't hear made that you think ought to be made. We'll be glad to receive it. We'll both obviously be here in the future to meet with various groups of veterans and others concerned about this medical center and that at Newington as well.

I want to thank everyone for their participation. I want to thank the staff of the Veterans' Affairs committee for their help in making this hearing possible, and for living through a tough day of trying to get from Long Island to Connecticut in the middle of the fog and the thunderstorms.

We thank you all and look forward to seeing you again. The hearing is hereby adjourned.

[Whereupon, at 6:30 p.m., the subcommittee was adjourned.]

APPENDIX

STATEMENT OF
HONORABLE LANE EVANS
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
FIELD HEARING
WEST HAVEN MEDICAL CENTER, CONNECTICUT
MAY 15, 1989

MR. CHAIRMAN, THANK YOU FOR CONDUCTING THIS IMPORTANT HEARING TODAY WHICH WILL EXAMINE THE DELIVERY OF HEALTH CARE SERVICES BY DVA MEDICAL CENTERS IN CONNECTICUT. I APPRECIATE BEING GIVEN THIS OPPORTUNITY TO TESTIFY AND I REGRET I'M NOT ABLE TO PRESENT MY TESTIMONY IN PERSON THIS MORNING. MANY WITNESSES ARE SCHEDULED TO TESTIFY TODAY AND I WILL BE BRIEF IN MY REMARKS SO THAT OTHERS WILL ALSO HAVE AMPLE OPPORTUNITY TO MAKE THEIR VIEWS KNOWN TO THE SUBCOMMITTEE.

BEFORE BEGINNING MY STATEMENT, MR. CHAIRMAN, I WANT TO COMMEND BOTH YOU AND JOHN ROWLAND FOR THE LEADERSHIP WHICH YOU HAVE DEMONSTRATED ON BEHALF OF ALL VETERANS AND ESPECIALLY CONNECTICUT VETERANS. THIS TIMELY HEARING EXEMPLIFIES YOUR CONTINUING COMMITMENT TO THE VETERANS OF THIS STATE. I SALUTE YOU AND CONGRESSMAN ROWLAND FOR YOUR TIRELESS EFFORTS ON BEHALF OF CONNECTICUT'S VETERANS.

MR. CHAIRMAN, AS YOU KNOW, SEVERAL WEEKS AGO AT YOUR REQUEST I MADE A FACT-FINDING VISIT TO THE WEST HAVEN MEDICAL CENTER IN MY OFFICIAL CAPACITY AS CHAIRMAN OF THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS. DURING THAT VISIT, I HAD THE OPPORTUNITY TO VISIT WITH OR OBSERVE MANY MEDICAL CENTER EMPLOYEES. EACH OF THOSE INDIVIDUALS WAS CLEARLY COMMITTED TO PROVIDING QUALITY MEDICAL CARE TO THE VETERANS THEY SERVE. IT WAS EQUALLY CLEAR, HOWEVER, THAT THE WEST HAVEN MEDICAL CENTER FACES SIGNIFICANT CHALLENGES IN CONTINUING TO PROVIDE QUALITY CARE WITH THE CURRENT LEVEL OF RESOURCES. AN INFUSION OF ADDITIONAL RESOURCES IS NEEDED IF OUR VETERANS ARE TO RECEIVE THE QUALITY OF CARE THEY EXPECT AND DESERVE TO RECEIVE.

MR. CHAIRMAN, THE PHYSICAL FACILITIES OF THE WEST HAVEN MEDICAL CENTER MUST BE IMPROVED. EVEN THE MOST DEDICATED CORPS OF HEALTH CARE PROVIDERS CAN NOT PROVIDE THE HIGHEST QUALITY OF CARE IN FACILITIES WHICH ARE FALLING DOWN AROUND THEM, LITERALLY. ACCORDING TO DIRECTOR BROWNE, WHO HAS BROUGHT ENERGETIC AND COMMITTED LEADERSHIP TO THE MEDICAL CENTER, CATASTROPHIC BUILDING WALL FAILURE IS EXPECTED TO OCCUR AT THIS FACILITY. WHEN THIS HAPPENS, LARGE SECTIONS OF BRICK WALL ARE EXPECTED TO BREAK AWAY AND FALL FROM MEDICAL CENTER BUILDING WALLS. COMMON SENSE TELLS US CORRECTIVE ACTION MUST BE TAKEN TO PREVENT THIS CATASTROPHE AND IT MUST BE TAKEN NOW BEFORE IT IS TOO LATE.

THE DELIVERY OF HIGH QUALITY MEDICAL CARE ALSO REQUIRES AN ADEQUATE NUMBER OF QUALIFIED HEALTH CARE PROVIDERS AND SUPPORTING PERSONNEL. TODAY, THE WEST HAVEN MEDICAL CENTER IS STRUGGLING, AND IN SOME CASES SIMPLY NOT ABLE, TO RECRUIT, TRAIN AND RETAIN THOSE EMPLOYEES. IF A MEDICAL CENTER HOPES TO RECRUIT AND RETAIN NEEDED EMPLOYEES, THE WAGES AND SALARIES WHICH IT OFFERS MUST BE ATTRACTIVE AND COMPETITIVE; TODAY, WITHOUT SPECIAL PAY, IN MANY CASES IT ISN'T. AS A RESULT, PATIENT MEDICAL FILES AREN'T BEING MAINTAINED ADEQUATELY BECAUSE THE MEDICAL ADMINISTRATION SERVICE DOESN'T HAVE ENOUGH EMPLOYEES, IMPORTANT EQUIPMENT MAINTENANCE IS BEING DEFERRED INDEFINITELY, AND ESSENTIAL EMPLOYEES, LIKE NURSING ASSISTANTS, CAN RECEIVE HIGHER PAY BY WORKING FOR MCDONALDS. AND THESE ARE BUT A FEW EXAMPLES, MR. CHAIRMAN, OF THE PROBLEMS CONFRONTING THE MEDICAL CENTER TODAY AS IT STRIVES TO PROVIDE QUALITY MEDICAL CARE WITHOUT ADEQUATE RESOURCES.

ALTHOUGH I AM COMMITTED TO BEING BRIEF, SPECIAL ATTENTION MUST BE GIVEN TO THE RESOURCE NEEDS OF THE BLIND REHABILITATION SERVICE AT WEST HAVEN. AS YOU KNOW, MR. CHAIRMAN, THE MEDICAL CENTER IS FORTUNATE TO HAVE BOTH A BLIND REHABILITATION CENTER AND A BLIND REHABILITATION CLINIC. BECAUSE OF INADEQUATE RESOURCES, HOWEVER, THESE PROGRAMS ARE NOT PROVIDING THE SERVICES WHICH ARE NEEDED. THE LAST THREE SERVICE-CONNECTED VETERANS ADMITTED TO THE BLIND REHABILITATION CLINIC WAITED AN AVERAGE OF 12 MONTHS FOR ADMISSION WHILE THE LAST THREE NON-SERVICE-CONNECTED VETERANS ADMITTED WAITED AN AVERAGE OF 20 MONTHS FOR ADMISSION.

ALTHOUGH THE WAITING TIME FOR ADMISSION TO THE BLIND REHABILITATION CENTER IS SOMEWHAT LESS, 216 APPLICANTS ARE CURRENTLY WAITING FOR ADMISSION TO EITHER THE CENTER OR CLINIC. THIS IS NOT QUALITY CARE.

MR. CHAIRMAN, TODAY THERE ARE ONLY 5 CLINIC BEDS AND 25 CENTER BEDS. I RECOMMEND INCREASING THE NUMBER OF CLINIC BEDS FROM 5 TO 15 AND INCREASING THE NUMBER OF CENTER BEDS TO 30 FROM THE CURRENT 25. THESE ADDITIONAL RESOURCES ARE NEED NOW, NOT YEARS FROM NOW.

IN SUMMARY, LET ME SIMPLY SAY, IF DVA MEDICAL CENTERS IN CONNECTICUT ARE TO PROVIDE QUALITY MEDICAL SERVICES, SUFFICIENT RESOURCES MUST BE PROVIDED. WHILE IT IS SOMETIMES TRUE THAT MORE CAN BE DONE WITH LESS, WE CAN NEVER DO EVERYTHING WITH NOTHING.

THANK YOU, MR. CHAIRMAN, FOR THIS OPPORTUNITY TO TESTIFY, FOR YOUR LEADERSHIP IN CONDUCTING THIS IMPORTANT HEARING TODAY AND FOR YOUR COMMITTED WORK ON BEHALF OF CONNECTICUT'S VETERANS.

TESTIMONY

BY

ALBERT B. WASHKO

REGIONAL DIRECTOR, NORTHEASTERN REGION

VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION

DEPARTMENT OF VETERANS AFFAIRS

MY TESTIMONY TODAY WILL FOCUS ON THREE MAIN AREAS. FIRST, THE IMPACT OF LIMITED RESOURCES ON THE QUALITY AND QUANTITY OF CARE PROVIDED TO VETERANS IN THE NORTHEASTERN REGION. SECONDLY, PROBLEMS WITH RECRUITMENT AND RETENTION WHICH ADVERSELY EFFECT BOTH QUALITY AND QUANTITY OF SERVICES PROVIDED. THIRD, WHAT THE NORTHEAST REGION IS DOING TO PROMOTE QUALITY CARE TO OUR VETERAN PATIENTS.

IMPACT OF LIMITED RESOURCES ON QUALITY OF CARE

I HAVE BECOME INCREASINGLY CONCERNED WITH HOW LIMITED RESOURCES ARE AFFECTING QUALITY OF CARE PROVIDED TO THE VETERANS IN THE NORTHEASTERN REGION. AT THE ADVICE OF SOME KEY CLINICAL AND ADMINISTRATIVE LEADERS IN THIS REGION, I ASKED ALL OF THE DIRECTORS TO RESPOND TO SOME SPECIFIC QUESTIONS I POSED TO PROVIDE ME WITH A BETTER PERSPECTIVE CONCERNING THIS ISSUE. I WILL SHARE WITH YOU SOME OF THE INFORMATION THAT THE DIRECTORS IN THIS REGION PROVIDED IN NOVEMBER OF 1988 IN ORDER TO GIVE YOU SOME INDICATION OF THE IMPACT OF LIMITED RESOURCES ON THE QUALITY OF CARE PROVIDED TO OUR VETERANS.

WHILE THE INFORMATION WAS OBTAINED LAST NOVEMBER, I BELIEVE THAT IT ACCURATELY REFLECTS THE CURRENT SITUATION THAT MOST FACILITIES ARE EXPERIENCING. NONETHELESS, I AM IN THE PROCESS OF REASSESSING THIS SITUATION IN ORDER TO OBTAIN A MORE CURRENT PERSPECTIVE.

I WILL PROVIDE FOUR CATEGORIES OF INFORMATION WHICH I RAISE CONCERNS REGARDING THE QUALITY OF CARE PROVIDED TO VETERANS IN THE NORTHEASTERN REGION AND REQUIRE CAREFUL MONITORING ON OUR PART:

- INABILITY TO FUND PATIENT CARE EQUIPMENT NEEDS,
- ELIMINATION OR LIMITATION OF KEY SERVICES,
- EXCESSIVE WAITING TIMES FOR CLINIC APPOINTMENTS AND
- EXCESSIVE WAITING TIMES FOR ALTERNATIVE LEVELS OF CARE

I CONSIDER THE INABILITY TO FUND PATIENT CARE EQUIPMENT NEEDS AS A MATTER OF REAL CONCERN FOR THE NORTHEASTERN REGION BECAUSE THIS DIRECTLY AFFECTS THE DIAGNOSIS AND TREATMENT OF VETERANS. IN NOVEMBER OF 1988, DIRECTORS IN THE NORTHEASTERN REGION WERE ASKED TO IDENTIFY PATIENT CARE RELATED REPLACEMENT EQUIPMENT NEEDS WHICH COST GREATER THAN $50,000 FOR INDIVIDUAL OR MULTIPLE ITEMS AND WHICH COULD NOT BE FUNDED IN FY 89.

THE MEDICAL CENTER HERE AT NORTHPORT IDENTIFIED APPROXIMATELY $1,876,000 IN NEEDED REPLACEMENT EQUIPMENT. THE NORTHEASTERN REGION HAD A TOTAL OF APPROXIMATELY $38,000,000 OF REPLACEMENT EQUIPMENT NEEDS COSTING GREATER THAN $50,000 FOR INDIVIDUAL OR MULTIPLE ITEMS.

IN NOVEMBER, THE MAJORITY OF THE NORTHEASTERN REGION'S DIRECTORS ALSO REPORTED INFORMATION WHICH INDICATED THAT KEY SERVICES ARE LIMITED OR NO LONGER AVAILABLE. WHILE THE TYPE OF SERVICES VARIED ACROSS FACILITIES, ALL FACILITIES REPORTED KEY SERVICES WHICH HAVE BEEN AFFECTED.

IN GENERAL, THE LIST OF KEY SERVICES WHICH HAVE BEEN LIMITED OR ARE NO LONGER PROVIDED AFFECTS THE QUALITY OF CARE IN AT LEAST SEVERAL WAYS: BY CAUSING DELAYS IN DIAGNOSIS OR IN TREATMENTS; BY CAUSING A DECREASE IN THE AMOUNT OF TIME THAT CAN BE DEVOTED TO QUALITY ASSURANCE ACTIVITIES.

ANOTHER AREA THAT I ASKED DIRECTORS ABOUT WAS EXCESSIVE WAITING TIMES FOR CLINIC APPOINTMENTS. THESE TIMES VARY ACROSS FACILITIES BY TYPE OF CLINIC BUT THE MAJORITY OF THE NORTHEASTERN REGION FACILITIES REPORT EXCESSIVE WAITING TIMES IN AT LEAST SOME OF THEIR CLINICS. AGAIN, IN GENERAL, THIS AFFECTS QUALITY OF CARE BY CAUSING DELAYS IN DIAGNOSIS OR IN PROVIDING TREATMENTS.

FINALLY, INFORMATION ABOUT WAITING TIMES FOR ALTERNATIVE LEVELS OF CARE INDICATES THE EFFECTS OF LIMITED RESOURCES ON QUALITY. AGAIN THESE TIMES VARY ACROSS THE REGION IN TERMS OF THE NUMBER OF PATIENTS AFFECTED AND THE WAITING TIMES BUT THE MAJORITY OF FACILITIES IN THE NORTHEASTERN REGION REPORT EXCESSIVE TIMES.

IN GENERAL, WAITING TIMES FOR ALTERNATIVE LEVELS OF CARE INDICATES THAT SERVICES, THE MAJORITY BEING ACUTE CARE, ARE BEING INAPPROPRIATELY USED FOR PATIENTS WHO DO NOT HAVE THESE NEEDS. FOR EXAMPLE, USING ACUTE CARE SERVICES FOR PATIENTS WITH LONG TERM CARE (NURSING HOME) NEEDS. MOREOVER, PATIENTS IN AN APPROPRIATE SETTING, SUCH AS LONG TERM CARE PATIENTS IN AN ACUTE CARE WARD, WILL NOT HAVE THEIR LONG TERM CARE NEEDS ADEQUATELY ADDRESSED.

IN NOVEMBER OF 1988, THE MAJORITY OF THIS REGION'S FACILITIES REPORTED WAITING TIMES FOR ALTERNATIVE LEVELS OF CARE. AT THE MEDICAL CENTER HERE AT NORTHPORT, 43 PATIENTS WERE WAITING AN AVERAGE OF 56 DAYS.

RECRUITMENT AND RETENTION ISSUES

IN 1988 AND 1989, THE FEDERAL EXECUTIVE BOARD IN NEW YORK CITY AND BOSTON PUBLISHED STUDIES ON THE EFFECTS OF PAY POLICY ON PUBLIC SERVICE. THESE STUDIES HIGHLIGHT AN EMPLOYMENT CRISIS. THE FEDERAL GOVERNMENT CAN NO LONGER COMPETE WITH PRIVATE INDUSTRY FOR QUALITY EMPLOYEES AND FEDERAL EMPLOYERS ARE FINDING IT INCREASINGLY DIFFICULT TO HIRE AND RETAIN GOOD AND BRIGHT EMPLOYEES WHO CAN PROVIDE QUALITY, TIMELY, AND RELIABLE PUBLIC SERVICES.

THE SALARY GAP BETWEEN THE PUBLIC AND PRIVATE SECTORS IS IN EXCESS OF 25 PERCENT AND THE GAP IS INCREASING. OVER TIME, THIS TREND WILL FURTHER ERODE THE FEDERAL GOVERNMENT'S ABILITY TO COMPETE IN THE LOCAL LABOR MARKET.

THE HEALTH AND WELL BEING OF HUNDREDS OF THOUSANDS OF AMERICAN VETERANS IS THE RESPONSIBILITY OF THE VARIETY OF TECHNICAL AND PROFESSIONAL EMPLOYEES OF 172 VA MEDICAL CENTERS. THE INABILITY TO PROPERLY STAFF THE MEDICAL CENTERS IS NOT ONLY A BUDGET ISSUE BUT A PAY ISSUE. THE FOLLOWING IS A BRIEF SYNOPSIS OF SOME OF THE CRITICAL STAFFING PROBLEMS AT THREE VA MEDICAL CENTERS IN THE NORTHEAST.

VAMC BOSTON

REGISTERED NURSES (RN'S)

AT THE PRESENT TIME, BOSTON HAS VACANT RN POSITIONS WHICH EQUATE TO 47.1 FTEE. THEY ARE UTILIZING FEE BASIS RN'S WHO RECEIVE: $23/HR FOR WEEKDAYS; $24/HR EVEN/NIGHTS; AND $24/HR WEEKEND DAYS; AND $25/HR WEEKEND EVEN/NIGHTS. AGENCY RN COSTS AVERAGE ABOUT $1,200/DAY. ACCORDINGLY, THE ESTIMATED COST OF A FEE BASIS NURSE IS $52,000 AND FOR A CONTRACT NURSE $65 TO $75,000 ANNUALLY.

WITH THE COST OF LIVING INCREASE IN JANUARY 1989, AND THE CURRENT SPECIAL RATES FOR RN'S, WE ARE PAYING OUR JUNIOR GRADE NURSES $28,072 (EQUIVALENT TO JUNIOR/19), AND ASSOCIATE GRADE NURSES $32,833 (EQUIVALENT TO ASSOCIATE/19). HOWEVER, THEY ARE STILL NOT COMPETITIVE SINCE THE COMMUNITY OFFERS ON AN AVERAGE $3,300 MORE IN SALARY FOR JUNIOR GRADE RN'S THAN WE DO AND $3,677/YR MORE TO ASSOCIATE GRADE NURSES. THIS DOES NOT TAKE INTO CONSIDERATION THE BONUS MONEY PAID BY LOCAL HOSPITALS ($2,000) IF THE NURSE WILL REMAIN WITH THE HOSPITAL FOR A YEAR.

THE CURRENT SPECIAL RATES FOR NURSES AT THE JUNIOR AND ASSOCIATE GRADE LEVELS ARE THE HIGHEST LEGAL LEVEL VACO CAN GO AND IT WILL TAKE LEGISLATION TO RAISE THIS CAP IF WE ARE TO BE ABLE TO MEET THE COMMUNITY RATES IN THE FUTURE.

LICENSED PRACTICAL NURSES (LPN'S)

AT THE PRESENT TIME BOSTON HAS 54.2 FTEE IN VACANT LPN POSITIONS. THE LATEST SURVEY TO SUPPORT A NEW SPECIAL RATE FOR LPN'S REFLECTS THAT THE MINIMUM RATE OFFERED IN THE COMMUNITY FOR NEW GRADUATES IS $23,676/YR VERSUS OUR MAXIMUM SALARY OF $19,649/YR GS-3 LPN'S. THE AVERAGE RATE FOR LPN'S IN THE COMMUNITY EQUAL TO OUR GS-6 LEVEL RECEIVE $30,927/YR VERSUS OUR MAXIMUM RATE OF $26,379/YR. ACCORDINGLY, THEY ARE BEHIND AN AVERAGE OF $4,027/YR AT THE GS-3 LEVEL AND $4,548/YR AT THE GS-6 LEVEL. ANY NEW SPECIAL RATE WILL BE LIMITED BY LEGISLATED MAXIMUM ENTRY LEVELS.

****RADIOLOGY TECHS****

AT THE PRESENT TIME, BOSTON VAMC HAS 19.7 FTEE IN VACANT RADIOLOGY TECH POSITIONS (OUT OF 36 FTEE AUTHORIZED). A NEW SPECIAL RATE PACKAGE HAS BEEN SUBMITTED TO OPM WHICH WILL COVER GS-4 TO GS-11 WITH MINIMUM A RATE OF $22,509 (GS-4) TO $36,548 (GS-11). INFORMATION PROVIDED FROM THE SERVICE AND APPLICANTS HAS INDICATED THAT THESE MAY BE CONSERVATIVE AND NOT AS ATTRACTIVE AS LOCAL HOSPITAL RATES. A SHORTAGE OF QUALIFIED APPLICANTS HAS EXISTED IN THIS CITY FOR ABOUT THREE YEARS; AND AS THE TECHNOLOGY EXPANDS, MORE STAFF TECHS ARE SELECTING SPECIALIZED FIELDS WITHIN RADIOLOGY. OUR ANNUAL COST OF A CONTRACT RADIOLOGY TECH IS APPROXIMATELY $50,000.

VAMC BROOKLYN

DURING THE LAST FEW YEARS, THE PAY DISPARITY BETWEEN FEDERAL EMPLOYEES AND THE PRIVATE SECTOR HAS INCREASED TO THE POINT THAT RECRUITMENT IN SOME AREAS IS VIRTUALLY IMPOSSIBLE. THIS PROBLEM IS PARTICULARLY CRITICAL WITH THOSE POSITIONS THAT PROVIDE DIRECT AND INDIRECT PATIENT CARE. THERE ARE MANY EXAMPLES WHICH COULD BE CITED.

BROOKLYN VAMC HAS TRIED TO ALLEVIATE THE PROBLEM OF PAY DISPARITY THROUGH THE USE OF SPECIAL RATES. HOWEVER, DUE TO THE WIDENING GAP, EVEN THE INSTITUTION OF SPECIAL RATES HAS MANY TIMES NOT IMPROVED RECRUITMENT. THE MOST GLARING EXAMPLE OF THIS IS THE TROUBLE BROOKLYN HAS EXPERIENCED IN RECRUITING PHYSICAL AND OCCUPATIONAL THERAPISTS. IN 1987, THEY INCREASED THE SPECIAL RATES FOR THESE POSITIONS TO THE MAXIMUM EXTENT POSSIBLE. HOWEVER, THEY STILL WERE NOT ABLE TO ATTRACT APPLICANTS. THEY SIMPLY COULD NOT COMPETE WITH THE PRIVATE SECTOR IN TERMS OF SALARIES AND BENEFITS. IN VIEW OF THIS, THEY WERE FORCED TO CONTRACT FOR PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS WHICH LAST YEAR COST THEM $42.00 PER HOUR. THIS EQUATES TO $88,000 PER PERSON, PER YEAR, ON CONTRACT. CURRENTLY, THE MOST THEY COULD OFFER A GS-9 STEP 10 ON THEIR SPECIAL RATES WOULD BE $36,636. THEIR TOTAL CONTRACT WAS APPROXIMATELY $300,000 FOR THE YEAR. THEY HAVE BEEN INFORMED THAT THE HOURLY RATE HAS INCREASED TO $47.00 PER HOUR.

BROOKLYN NOW FACES A SIMILAR PROBLEM WITH DIAGNOSTIC RADIOLOGIC TECHNOLOGISTS. THEY RECEIVED SPECIAL RATES IN JANUARY, 1988. THEY CURRENTLY HAVE A REQUEST PENDING WITH OPM FOR AN INCREASE IN RATES. DESPITE ACTIVE RECRUITMENT EFFORTS, THEY HAVE BEEN UNABLE TO RECRUIT ANY DIAGNOSTIC RADIOLOGIC TECHNOLOGISTS. SEVERAL ADS HAVE BEEN RUN IN THE NEW YORK TIMES OVER THE LAST FEW WEEKS. TO DATE, THEY HAVE NOT RECEIVED EVEN ONE RESPONSE TO AN AD.

WITH THE SUMMER MONTHS COMING, THEY ARE EXTREMELY CONCERNED ABOUT VACATION COVERAGE. THEIR ONLY ALTERNATIVE MAY BE TO CONTRACT OUT. THE APPROXIMATE COST OF CONTRACTING OUT WOULD BE $40.00 PER HOUR. THIS WOULD EQUATE TO APPROXIMATELY $83,000 PER YEAR. A GS-7 STEP 10 ON SPECIAL RATES CURRENTLY MAKES $29,940 PER YEAR.

BROOKLYN VAMC HAS BEEN RECRUITING FOR SOME DIETITIAN AND POLICE OFFICER VACANCIES FOR MORE THAN A YEAR IN SPITE OF THE EXISTENCE OF SPECIAL RATES AND ACTIVE RECRUITMENT EFFORTS. NEEDLESS TO SAY, THE PAY DISPARITY IS HAVING AN ADVERSE EFFECT ON QUALITY PATIENT CARE. RECENTLY A "HEAD-HUNTING' FIRM OFFERED THEIR CHIEF, DIETETIC SERVICE $70,000 AS AN ADMINISTRATIVE DIETITIAN. A GS-11 STEP 10 ADMINISTRATIVE DIETITIAN MAKES $38,659 ON OUR SPECIAL RATE SCALE.

THE FEDERAL PAY DISPARITY HAS ALSO HINDERED THEIR ABILITY TO RECRUIT TITLE 38 SERVICE CHIEFS. BROOKLYN HAS BEEN RECRUITING FOR A CHIEF, SURGICAL SERVICE FOR NEARLY TWO YEARS; THE CHIEF, RADIOLOGY SERVICE LEFT IN DECEMBER, 1988; AND THEY ARE NOT OPTIMISTIC IN FILLING THIS POSITION ANYTIME IN THE NEAR FUTURE DESPITE ACTIVE RECRUITMENT EFFORTS AND ENHANCEMENTS MADE BY THEM AND DOWNSTATE MEDICAL CENTER. TO COMPOUND THIS PROBLEM, THEY ANTICIPATE THAT THE CHIEF, ANESTHESIOLOGY SERVICE WILL BE RETIRING THIS FALL. RECRUITING A REPLACEMENT QUICKLY IS DOUBTFUL. CONTRACTING OF THESE POSITIONS WOULD BE WELL OVER $200,000.

THE ABOVE PAY DISPARITY IS NOT UNIQUE TO THE VA. IT IS A SEVERE PROBLEM WHICH EXISTS IN ALL FEDERAL AGENCIES IN THE NEW YORK CITY AREA.

IN AUGUST 1988, THE NEW YORK FEDERAL EXECUTIVE BOARD BEGAN WORKING WITH THE FBI ON A SPECIAL PAY PROJECT FOR THE ENTIRE NYC AREA. THIS PROJECT WAS AN EFFORT TO ADDRESS THE GROWING CRISIS FACING THE FEDERAL GOVERNMENT IN NEW YORK IN TERMS OF RECRUITING AND RETAINING A QUALIFIED WORK FORCE. SINCE AUGUST, THE FEB HAS BEEN GATHERING AND PRESENTING DATA IN ACCORDANCE WITH THE SPECIAL SALARY RATES PROCESS. BASED ON THESE STUDIES, CRITICAL STAFFING SHORTAGES HAVE BEEN REPORTED AMONG PROFESSIONAL, ADMINISTRATIVE, TECHNICAL AND CLERICAL EMPLOYEES. THERE IS ALSO A GROWING CONCERN ABOUT THE POTENTIAL IMPACT THIS LOWER QUALITY WORK FORCE WILL HAVE ON AGENCY AND DEPARTMENT OPERATIONS.

THE FEB HAS FOUND THAT THERE IS A GAP OF MORE THAN 25 PERCENT BETWEEN GOVERNMENT SALARIES AND WAGES IN THE PRIVATE SECTOR. THERE IS A TREMENDOUS PRIVATE SECTOR JOB GROWTH, COMBINED WITH A TIGHT LABOR MARKET, AND THE RESULT IS SEVERE RECRUITMENT AND RETENTION PROBLEMS FOR FEDERAL AGENCIES IN THE AREA. THE NEW YORK AREA HAS THE HIGHEST COST OF LIVING IN THE NATION WITH THE POSSIBLE EXCEPTION OF ANCHORAGE, ALASKA; A CITY THAT IS SUPPLEMENTED BY A 25 PERCENT COLA.

IN OCTOBER 1988, THE FEB SUBMITTED A GROUP OF 81 OCCUPATIONAL SERIES TO THE OFFICE OF PERSONNEL MANAGEMENT FOR CONSIDERATION UNDER THE SPECIAL SALARY RATE REGULATION. OPM ADVISED THE FEB, IN ITS ROLE AS LEAD AGENCY, TO SELECT THE MOST SEVERE PROBLEMS AMONG THE MULTI-AGENCY SERIES FOR CONSIDERATION UNDER THE SPECIAL SALARY RATE PROCESS, AS CITED IN 5 USC 5303. THE FEB HAS REVIEWED THE DATA FOR ALL SERIES AND HAS SELECTED 28 MULTI-AGENCY SERIES WHICH REPRESENT THE MOST SEVERE PROBLEMS IN TERMS OF RECRUITMENT AND RETENTION. A PACKAGE REQUESTING SPECIAL RATES FOR THESE 28 OCCUPATIONS HAS BEEN SUBMITTED TO OPM FOR APPROVAL.

FEB HAS ASKED BROOKLYN TO SUBMIT THE APPROPRIATE SPREAD-SHEETS AND NARRATIVES WHICH THEY HAVE COMPLETED TO VA CENTRAL OFFICE AS SOON AS POSSIBLE, REQUESTING APPROVAL AND CERTIFICATION OF FUNDS TO SUPPORT SPECIAL SALARY RATES FOR THOSE SERIES THAT ARE APPLICABLE TO THE BRONX, MANHATTAN AND BROOKLYN VA'S.

V.A. MEDICAL CENTER NEW YORK

COST COMPARISON

EMPLOYMENT VS CONTRACT

CURRENT CONTRACT COSTS

SERVICE	POSITION	# STAFF	VA SALARY	CONTRACT COST
MAS	TELEPHONE OPERATORS	6	$6.74PH	$12.00PH
RADIOLOGY	DRT	6	$10.71PH*	$32.50PH
ANESTHESIOLOGY	PHYSICIAN (CHIEF)	1	$94,121**	$255,920**

* SALARY BASED ON GS-6 STEP 1 (SPECIAL RATE)

** VA SALARY FOR CHIEF ANESTHESIOLOGY INCLUDES 19,181 BONUS

CONTRACT COST INCLUDES $26,000 FOR MALPRACTICE INSURANCE, WHICH EMPLOYEE'S WOULD NOT CARRY IF EMPLOYED BY VA.

POTENTIAL AREAS WHICH MAY BE CONTRACTED OUT

SERVICE	POSITION	# STAFF	VA SALARY	CONTRACT COST
SECURITY	POLICE OFFICER	4	$ 8.37PH*	$12.00PH
MEDICAL	ECHO TECH	1	$14.85PH**	$20.00PH
RMS	PHYSICAL	3	$15.68PH***	$21.00PH

* BASED ON A GS-5 STEP 1 (SPECIAL RATE)

** BASED ON A GS-9 STEP 9 (GENERAL SCHEDULE)

*** BASED ON A GS-9 STEP 5 (SPECIAL RATE)

PHYSICIAN RECRUITMENT/RETENTION

PHYSICIAN RECRUITMENT AND RETENTION HAS ALSO DETERIORATED. I AM BECOMING INCREASINGLY CONCERNED WITH THE INABILITY OF MANY OF OUR VA MEDICAL CENTERS TO RECRUIT AND RETAIN WELL QUALIFIED PHYSICIANS. WE RECENTLY SURVEYED THE 23 VAMC'S IN THE NORTHEASTERN REGION TO ASSESS THE MAGNITUDE OF THE PROBLEM AND TO DETERMINE IF PHYSICIAN RECRUITMENT AND RETENTION WAS ADVERSELY AFFECTING THE QUALITY PATIENT CARE.

WE FOUND THAT 21 OF 23 VAMC'S ARE EXPERIENCING RECRUITING DIFFICULTIES IN ONE OR MORE PHYSICIAN CATEGORIES. THREE MEDICAL CENTERS HAVE VACANCIES FOR RADIOLOGISTS, PSYCHIATRISTS, ORTHOPEDISTS, AND CARDIO-VASCULAR SURGEONS IN EXCESS OF ONE YEAR. MOST MEDICAL CENTERS ARE ABLE TO RECRUIT JUNIOR, ENTRY LEVEL, PHYSICIANS IN INTERNAL MEDICINE AND AMBULATORY CARE BUT EXPERIENCE GREAT DIFFICULTY IN RECRUITING ENTRY LEVEL PSYCHIATRISTS, RADIOLOGISTS, ANESTHESIOLOGISTS, AND SUB-SPECIALTY SURGEONS. RECRUITMENT OF MORE SENIOR PHYSICIANS WITH MORE ADVANCED EXPERIENCE AND SKILLS IS EXTREMELY DIFFICULT AND LEAVES CLINICAL SERVICES WITHOUT ADEQUATE SUPERVISION, LEADERSHIP AND EXPERTISE.

SALARIES AND FRINGE BENEFITS WHICH ARE NOT COMPETITIVE WITH THE ACADEMIC AND PRIVATE SECTOR ARE THE MAJOR NEGATIVE FACTORS IN RECRUITMENT AND RETENTION. THE SALARY GAP WIDENS IN THE MORE SENIOR LEVEL POSITIONS. THE RESULTING "COMPRESSION" OF PAY LEVELS CAUSES A MAJOR RETENTION PROBLEM WITH VA STAFF WHO HAVE FACULTY APPOINTMENTS AT ASSOCIATE AND FULL PROFESSOR LEVELS BUT WHOSE SALARY IS COMMENSURATE WITH INSTRUCTOR AND ASSISTANT PROFESSOR FACULTY AT OTHER AFFILIATED HOSPITALS.

WHAT THE NORTHEAST REGION IS DOING TO PROMOTE QUALITY

I AM DEEPLY CONCERNED AND COMMITTED TO PROVIDING HIGH QUALITY OF CARE TO OUR VETERANS. FROM THE TIME I BECAME THE DIRECTOR OF THE NORTHEASTERN REGION, I HAVE AGGRESSIVELY PROMOTED AND SUPPORTED THE MANAGEMENT OF QUALITY. IN ADDITION TO ADEQUATE RESOURCES, INCLUDING BOTH PERSONNEL AND EQUIPMENT, I HAVE IDENTIFIED TWO ESSENTIAL ELEMENTS FOR ACHIEVING HIGH QUALITY OF CARE. THEIR IMPLEMENTATION WILL RESULT IN ESTABLISHING A CYCLE OF CONTINUOUS IMPROVEMENT. TO ACHIEVE HIGH QUALITY CARE, TWO PROCESSES ARE REQUIRED: 1) SERVICE MANAGEMENT AND 2) QUALITY MANAGEMENT.

SERVICE MANAGEMENT IS A MANAGEMENT PHILOSOPHY WHICH IS BEING COMMUNICATED TO ALL MANAGERS AND EMPLOYEES IN THE NORTHEAST REGION. THE KEY CONCEPT IN THIS MANAGEMENT PHILOSOPHY IS EXCELLENCE IN THE PROVISION OF SERVICE; SERVICE TO OUR VETERAN PATIENTS AND THEIR FAMILIES AND SERVICE TO EACH OTHER AS FELLOW EMPLOYEES AND COLLEAGUES. OUR OUTCOME VISION FOR SERVICE EXCELLENCE MANAGEMENT IS TO HAVE THE BEST MANAGED MEDICAL CENTERS IN THE COUNTRY; TO PROVIDE A HIGH CONSISTENT LEVEL OF SERVICE AND PERCEIVED QUALITY OF SERVICE TO PATIENTS, EMPLOYEES AND PHYSICIANS; AND TO PROVIDE AN ENHANCED EMPLOYEE AND MANAGEMENT CLIMATE FOR OUR PEOPLE TO WORK IN.

THERE ARE A NUMBER OF STRUCTURES IN PLACE TO SUPPORT THIS VISION, INCLUDING FIVE SEMINARS/WORKSHOPS FOR EVERY MANAGER IN THE NORTHEAST REGION AND TWO SEMINARS/WORKSHOPS FOR ALL EMPLOYEES. THIS TRAINING IS BEING PROVIDED BY MANAGEMENT COLLEGE FACULTY FROM WITHIN THE NORTHEAST REGION AND MYSELF. IN ADDITION, THERE ARE FIVE DATA SYSTEMS WHICH WILL SUPPORT THE ACCOMPLISHMENT OF OUR VISION. THESE ARE INSTRUMENTS WHICH MEASURE THE MANAGEMENT CLIMATE, EMPLOYEE CLIMATE, SERVICES PROVIDED TO EACH OTHER, SERVICES PROVIDED TO PHYSICIANS AND SERVICE PROVIDED TO PATIENTS.

SOME SPECIFIC OUTCOMES WHICH I HOPE TO ACCOMPLISH THROUGH THE SERVICE EXCELLENCE MANAGEMENT PROCESS IN THE NORTHEASTERN REGION ARE: 1) SETTING JOB STANDARDS WITHIN EACH SERVICE OR SECTION FOR ENCOUNTERS WITH VETERANS; THROUGH THE ACHIEVEMENT OF THESE STANDARDS, MAXIMIZE THE VETERAN'S, HIS OR HER FAMILY'S AND THE COMMUNITY'S PERCEPTION OF QUALITY SERVICE WITHIN EACH MEDICAL CENTER; 2) RECOGNIZE THE 'INTERNAL CUSTOMER' AND CREATE A HIGH LEVEL OF CONSISTENCY OF SERVICE THAT ONE EMPLOYEE RECEIVES FROM OTHER EMPLOYEES, SECTIONS AND SERVICES; 3) CONTINUE TO BUILD MORE POSITIVE EMPLOYEE MORALE AND MANAGEMENT CLIMATE; 4) PROVIDE THE TOP MANAGEMENT TEAM IN EACH FACILITY WITH CONCISE EASY-TO-USE DATA TO KNOW HOW WELL THEIR HOSPITAL IS WORKING FROM A SERVICE DELIVERY AND AN EMPLOYEE AND MANAGEMENT CLIMATE STANDPOINT.

THE ESTABLISHMENT OF A QUALITY MANAGEMENT PHILOSOPHY AND INFORMATION SYSTEM IS THE SECOND PHASE IN MY STRATEGY, WHICH INVOLVES THE IMPLEMENTATION OF A MANAGEMENT COLLEGE TO TEACH STATISTICAL QUALITY CONTROL METHODS TO ALL STAFF. THROUGH A SYSTEM OF SEMINARS BEING PLANNED FOR NEXT YEAR, EVERY EMPLOYEE WILL LEARN THAT THEY HAVE A RESPONSIBILITY IN THE MANAGEMENT OF PATIENT CARE AND THAT THEIR ACTIONS CONTRIBUTE TOWARD THE ACHIEVEMENT OF HIGH QUALITY OF CARE IN THEIR HOSPITALS.

AGAIN, EVERY DIRECTOR AND HIS OR HER STAFF IN THE NORTHEASTERN REGION WILL BE INVOLVED. THE MEASUREMENT OF QUALITY OF CARE IS CURRENTLY ABSORBING NATIONAL RESOURCES, INCLUDING LEADING MEDICAL AND CLINICAL SOCIETIES, RESEARCH TEAMS AND BOTH GOVERNMENT AND PRIVATE SECTOR AGENCIES. IN SPITE OF THE COMPLEXITY OF THIS TASK, THIS REGION HAS MADE A MAJOR COMMITMENT TO IMPLEMENTING A QUALITY MANAGEMENT PHILOSOPHY AND INFORMATION SYSTEM WHICH APPLIES STATISTICAL QUALITY CONTROL METHODS TO MEASURE THE TECHNICAL ASPECTS OF CARE, (FOR EXAMPLE THE APPROPRIATENESS OF THE TREATMENT REGIMEN), AND OF THE HEALTH CARE DELIVERY SYSTEM IN EACH HOSPITAL (FOR EXAMPLE, THE ADEQUACY OF COMMUNICATING ABNORMAL TEST RESULTS, OR THE TIMELINESS OF SURGERY). FEW HEALTH CARE INSTITUTIONS HAVE MADE A COMMITMENT TO SUCH AN AMBITIOUS UNDERTAKING.

SPECIFICALLY, THE ESTABLISHMENT AND USE OF A COMPREHENSIVE QUALITY MANAGEMENT INFORMATION SYSTEM WILL PROVIDE THE CLINICIAN AT THE BEDSIDE, (A PHYSICIAN, NURSE OR SOCIAL WORKER), WITH TECHNICAL INFORMATION ABOUT THE QUALITY OF CARE FOR THE PURPOSE OF ACHIEVING THE BEST CLINICAL MANAGEMENT; FOR EXAMPLE, THE EARLY IDENTIFICATION OF UNEXPECTED COMPLICATIONS IN SURGICAL PATIENTS, THE EARLY DETECTION OF AN INAPPROPRIATELY PRESCRIBED TREATMENT FOR A PATIENT WITH CHRONIC LUNG PROBLEMS AND THE EVALUATION OF THE ADEQUACY OF DISCHARGE PLANS FOR DIABETIC PATIENTS LIVING ALONE.

THIS INFORMATION SYSTEM WILL ALSO CONTAIN DATA FOR MANAGERS AND WORKERS IN EACH HOSPITAL ABOUT THE EFFECTIVENESS OF THE HEALTH CARE DELIVERY SYSTEM IN THAT HOSPITAL SUCH AS THE TIMELINESS OF TESTS OR OTHER TYPES OF INFORMATION AND THE ADEQUACY OF ADMINISTRATIVE PROCEDURES. CONSEQUENTLY, EACH EMPLOYEE WILL BE ABLE TO SEE HOW HE OR SHE CONTRIBUTES TOWARD THE QUALITY OF CARE IN THEIR OWN INSTITUTION.

FINALLY, THE USE OF LONGITUDINAL PATIENT CARE AND DELIVERY SYSTEM INFORMATION WILL PROMOTE A PROCESS OF CONTINUOUS IMPROVEMENT BY BOTH CLINICIANS AND KEY HOSPITAL MANAGERS BECAUSE WE WILL BE ABLE TO MORE QUICKLY IDENTIFY THE BEST WAYS OF MANAGING THE VARIOUS TYPES OF CARE AND DELIVERY SYSTEM FUNCTIONS. MEDICAL CARE CAN ALWAYS FIND BETTER METHODS TO DIAGNOSE AND TREAT PATIENTS AND MANAGERS CAN ALWAYS FIND BETTER WAYS OF OPERATING. WE NEED HOWEVER TO COMMIT TO A PHILOSOPHY OF QUALITY MANAGEMENT AND CONTINUOUS IMPROVEMENT TO FIND THESE BETTER WAYS AND WE NEED TO IMPLEMENT AN OBJECTIVE QUALITY MANAGEMENT SYSTEM TO ACHIEVE THIS CONTINUOUS IMPROVEMENT PROCESS.

IN SPITE OF THE ACTIONS OF THIS REGION WHICH DEMONSTRATE OUR COMMITMENT TO QUALITY MANAGEMENT, I BELIEVE THAT OUR DIMINISHING RESOURCES MAY PROVIDE AN INSURMOUNTABLE OBSTACLE IN THE NEAR FUTURE. IN SHORT, QUALITY MANAGEMENT ACTIVITIES WILL ONLY RESULT IN THE DELIVERY OF HIGH QUALITY OF CARE WHEN THERE ARE ADEQUATE RESOURCES.

TESTIMONY FOR NORMAN E. BROWNE, DIRECTOR
VA MEDICAL CENTER, WEST HAVEN, CONNECTICUT
May 15, 1989

Good afternoon. My testimony today focuses on problems that VAMC West Haven is having in recruiting and retaining an adequate workforce. It is very difficult to provide quality patient care in the face of these problems.

For example, we have a 25 year old, worn out air conditioning system. Air conditioning is clinically important in a hospital, it is not just to provide comfort. Summers in New Haven are hot and muggy. We have four air conditioning mechanic positions to maintain and repair this system. Three of our four air conditioning positions are vacant and our one mechanic is about to accept a position that pays about 180 percent of the salary he earns at the VA.

Another example is that West Haven does the diagnostic work for tuberculosis for the VA nationwide. We recently succeeded in getting special pay rates for our medical technologists. Because the rates did not cover the microbiologists in the National TB Reference Lab, those employees are threatening to leave the VA. There are ample jobs they can take in the private sector which pay more money than the VA. If they leave, there will be a disruption to patient care in every VA in the country which depends on us for diagnostic work.

Another example is our payroll supervisor, Mike Holland. We recruited Mike from Louisiana because we had enormous problems in getting our employees paid. He is a very knowledgeable, excellent employee and has corrected many of our problems. He cannot afford to live here with his family on the salary we pay him even though he got a promotion to come here, so his wife and children have had to move back to Louisiana.

These are not isolated examples. We have entire sections of the hospital with 200-300 percent turnover rates. This means our entire staff in some sections quits every four months.

High quality medical care requires that nurses be able to get the clerical support they need, that doctors be able to find medical records, that the patients who need to be taken to the operating room can get an elevator. These things are not working well. Special salary rates have helped, but they do not solve the problems and they create anger and frustration in managers, for instance, who supervise employees who make more than the managers do.

Thank you. I would be happy to answer any questions.

STATEMENT OF ROBERT K. DAVENPORT, MEDICAL CENTER DIRECTOR,

VA MEDICAL CENTER, NEWINGTON, CONNECTICUT

BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTHCARE,

COMMITTEE ON VETERANS AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

MAY 18, 1989

Mr. Chairman and members of the subcommittee:

All of us are acutely aware of the financial crisis facing the Veterans Health Services and Research Administration and the impact and consequences this is having on the quality and quantity of health care services being provided.

Specifically with reference to the Veterans Affairs Medical Center Newington in FY89 we were facing a $1.2 million deficit in operating funds. The causes of this were a combination of decreasing workloads and duplication of clinical services that resulted in non cost effective programs. The financial deficit was further compounded by mandatory congressional budget cuts (i.e. 1% Productivity Reduction) and poor performance with the departments resource allocation model due to the facilities low workload and high expenditure levels.

Relative to our decreasing workload another factor that has influenced our actions was the disaffiliation of our residency programs in Surgery and Psychiatry by the University of Connecticut, School of Medicine. This disaffiliation was due to the Medical School not being able to meet the Residency Review Committee requirements for workload to provide a high quality medical resident training program. In FY88 the Surgical Subspecialty workloads consisted of only 51 discharges in Ophthamology, 107 in Orthopedics, 60 in ENT and 104 in Urology. Obviously the number and acuity of the workload for this facility was not sufficient to maintain a high quality standard of patient care or resident education, nor was it cost effective for the FTEE and other costs assigned to support these programs.

The result of these various factors led both Medical Centers to establish the Integrated Health Care Plan for Veterans in the State of Connecticut. The cornerstone of this plan was to provide top quality, cost effective health care to our current and aging veteran population within available resources. In developing this plan the geographical consideration of the two Medical Centers being 35 miles apart with easy highway access was prominent.

The integrated plan calls for all acute surgical and acute psychiatric inpatient care be provided at West Haven. Newington will still provide Surgical & Mental Health consultation and outpatient clinic services. West Haven's high patient volume and established Yale affiliated-residency program provides the appropriate environment for high quality tertiatary medical care.

The remainder of the integrated health care plan calls for Newington to continue ambulatory care services, maintain an acute inpatient medical bed service, and address and enhance the health care needs of the aging veteran. Newington will convert its surgical beds to Intermediate Care beds to provide Geriatric Medical/Rehab./Neurological and Psychiatric care to the aging veteran. Emphasis on the treatment and management of Alzheimer's disease, stroke rehabilitation, hospice, and ventilator dependent patients will be developed and stressed. To implement this initiative, Newington is working with the Traveler's Center on Aging and University of Connecticut, School of Medicine. The final outcome will be Newington serving as a Center of Excellence in Geriatric Care, thus expanding the long term care services to the veterans of Connecticut and complimenting the acute care provided at West Haven.

Although we feel the integrated plan is an exciting and novel answer to addressing the current and aging health care needs of veterans, a major detriment to the success of this program is the ability to recruit and retain qualified staff.

As noted earlier by Mr. Washko and Browne numerous clinical positions (Title 38) have received support and approval from both VACO and OPM for special pay rates. Our ability to recruit and retain clinical positions is still difficult because the special rates still do not match private sector salary and benefits. This problem also pertains to non-clinical administrative staff that receive no special pay rates. These positions though non-clinical provide both direct and indirect patient care activity support to the clinicians. Such positions involve ward secretaries and clinic clerks who process patient medical records, bio-medical technicians that maintain and repair hi-tech patient care equipment and key management service chiefs that currently earn less annually than an entry level staff R.N.. It is imperative that we be able to fill these support positions with qualified and trained/educated personnel.

In concert with some of the recruitment/retention problems I've just mentioned, Mr. Tom Brownell, Director of the Regional Office will be discussing the proposed relocation of the Regional Office to our Medical Center grounds. A major problem of the current downtown Hartford location is the inability to recruit a high caliber staff due to both the high cost of living in the Hartford area as well as an average $70.00 monthly parking fee. In addition, it poses a tremendous inconvenience for many veterans to reach the Regional Office due to the parking situation and transportation problems. I therefore fully support the co-location project as a means of better serving not only the veteran, but the recruitment/retention of staff at the VARO.

As a final comment, Veterans Affairs Medical Centers West Haven & Newington are "ON THE MOVE" in creating a cost effective and quality health care environment with such plans as our new medical bed tower, enhanced clinical programs with emphasis on geriatrics and a mutually supportive consortium approach to the delivery of healthcare services to the veterans of Connecticut.

STATEMENT OF THOMAS D. BROWNELL, DIRECTOR, VA REGIONAL OFFICE, HARTFORD, CONNECTICUT

BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTHCARE, COMMITTEE ON VETERANS AFFAIRS UNITED STATES HOUSE OF REPRESENTATIVES

MAY 15, 1989

Mr. Chairman and members of the subcommittee:

I would like to thank you for the opportunity to address the members of House Veterans Affairs Committee on behalf the Department of Veterans Affairs Hartford Regional Office. We are most appreciative of your interest in veterans' interests in this state and how we may best serve them.

One of our major concerns in this area is the issue of colocation. We wish to acknowledge the House Veterans Affairs Committee for their efforts to include our office in the FY 1990 budget proposal for the colocation initiative. Although severe budget constraints had eliminated the project from the FY 1990 schedule, the Department will reintroduce the project into the FY 1991 budget submission. We eagerly await the opportunity to colocate at the Newington Medical Center grounds.

From a mission viewpoint we believe that our clients would be best served if both the Regional Office and Medical Center were colocated. Veterans would receive one-stop service. Not only can they be treated for their medical problems, they can file the necessary benefits applications or review their claims. The new facility at Newington would also serve as an ideal location for the proposed consolidation of all New England loan guaranty activities.

Coexisting on the same grounds would facilitate coordination in obtaining medical evidence, eligibility, scheduling, verification, supplies, counseling and fee basis. Our adjudication and vocational rehabilitation staff could coordinate more effectively with allied medical staff on both inpatient and outpatient veterans, providing a more unified approach to obtaining necessary medical evidence and rehabilitation.

The Hartford Regional Office is currently located in a GSA Federal Courthouse Building at 450 Main Street, in the City of Hartford. We presently pay GSA $20.35 per square foot or approximately $750,000 per year standard level usage charge for this inner city location. Future plans call for additional renovations of this building to provide sufficient space for the federal courts. GSA has indicated that they can readily backfill any space we currently occupy once we vacate to a new location.

Physical security is lax due to manpower cutbacks. Because of frequent incidents of neighborhood vandalism, we expend almost 30 workdays a year garaging our GSA vehicles at the end of each day and removing them first thing every morning.

City officials are pursuing an active policy to reduce parking facilities and discourage vehicular traffic within City limits. Meanwhile, the public transportation system continues to deteriorate as the state is forced to rely on buses brought out of retirement. Veterans visiting our office, unable or unwilling to depend upon public transportation, must both find and pay for parking, neither of which is convenient to our location.

Private parking lots that are available in the general area cost from $70 to $85 a month. Private industry in the city routinely provides parking to their own employees as a fringe benefit or subsidizes their parking at private lots. Our inability to provide similar incentives precipitated critical clerical losses. Handicapped parking is limited to the point of being almost non-existent. The problems associated with inaccessibility would disappear with colocation.

Federal recruitment problems are commonplace throughout the nation, but are especially acute in this part of the country. In order to combat high turnover and improve recruitment, we functioned as Lead Agency to spearhead a consolidated Special Pay request for all GS-1 through GS-6 federal clerical employees in Connecticut. Our efforts led to OPM's granting of special salary rates approximately 10% higher than current GS rates.

Unfortunately, these rates are still not competitive when compared to current private industry and state/local government sectors. Preliminary data indicates that this year's consolidated rate request will be in the range of 15% - 17% and will include GS-7's and 8's in an attempt to narrow the pay gap.

In another effort to deal with employment problems, the Hartford Regional Office surveyed our employees and those at the Newington Medical Center on the need for a Federal Day Care Center and a wellness center. These are well established benefits in the private sector here and go far in recruiting/retaining trained employees. Survey responses to both initiatives were favorable and would make good sense at a colocation site.

We believe that colocation at Newington, combined with continued special pay or locality pay efforts, would enhance our recruitment and retention of employees as well as centralizing services to veterans and their dependents. Newington's close proximity to Hartford makes any potential disruption to servicing our clients minimal. Current public transportation services the Medical Center from Hartford.

We contend that the current location in the City of Hartford, along with the current local business environment, has adversely affected our ability to attract and retain quality personnel. We suffered a 33% turnover rate during calendar year 1988. This high turnover has contributed to the time lost to production inherent in training new employees. Generally, when new employees are recruited, they have tended to be less talented than those hired just 2 to 3 years ago, requiring more intensive training for longer periods of time.

The Veterans Benefits Administration (VBA), as part of the Department of Veterans Affairs, has been ordered to reduce overall employment from 12,650 to 12,100; a decrease of 550 FTE. This cut would be primarily directed at the regional offices. On a proportional basis, this translates to 5 less full time employees for the Hartford regional office. Interestingly, VBA has lost 6,000 FTEE since 1979. This represents an employment reduction of one-third of the VBA's workforce.

One of the ways we have attempted to deal with decreasing staffing, while providing our full array of services, is through organizational consolidation. By consolidating our former Administrative and Finance Divisions into one Support Services Division and reorganizing our Veterans Services Division to eliminate a supervisory position, we have reduced administrative overhead. This strategy is consistent with the Chief Benefits Director's goal of improved productivity and service to the veteran.

Despite high staffing turnovers, training strains and a relatively inexperienced workforce required to learn sophisticated equipment, procedures and regulations, we have been able to improve timeliness of benefits delivery and associated services. Pending workload a year ago at this time was running close to 7 days. Our current pending workload is a little over 2 1/2 days.

We have also been able to improve the productivity levels in each direct labor activity over last year's levels. Overall station productivity is up 35% over last year. We are emphasizing improvements in the quality of services we provide. Our station Quality Improvement Committee meets monthly to review quality performance findings, discuss weaknesses and recommend measures for improvement.

We rely ever more increasingly on office automation technology to accomplish our mission with less employees. While we embrace this philosophy, we recognize the need for a fully trained, competent, experienced workforce to operate and maintain this equipment.

Through our management and modernization efforts, we are accomplishing this without increasing our workforce ceiling which has been 93 FTEE for the past two fiscal years. Further ceiling reductions however, will severely impact our efforts to improve our operations.

In summary, it is our opinion that one of the ways to attract and retain competent personnel is to locate in an affordable area convenient to both the workforce and the public they serve. Colocation provides an answer to all these concerns. It provides a central location for veterans and their dependents to obtain both medical and benefit services, saving both time and money.

Most of the preparations have already been set in motion. We enjoy cordial relations with Mr. Davenport and his staff at the Newington Medical Center. Site plans have been prepared, initial building layouts have been explored and employees are enthusiastic about colocating to Newington. A memorandum of understanding between the Veterans Health Services and Research Administration and the Veterans Benefits Administration has been developed for mutual cooperation and sharing of common services.

All of this translates into better morale, better attitudes, a more effective workforce and better service. Colocation benefits everyone from the veteran looking for quality service to the employees providing these services. Our workforce needs to regain their self respect and image. They work hard to provide quality and timely service. They need to know that they are as good as their counterparts in other sectors. We need to demonstrate that to them. Colocation can do this for us.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

APR 18 1989

APR 14 1989

Honorable John G. Rowland
House of Representatives
Washington, D. C. 20515

Dear Mr. Rowland:

Thank you for your letter dated March 14, 1989, concerning the Clinical Addition at the Department of Veterans Affairs Medical Center (VAMC), West Haven, Connecticut.

The Clinical Addition project planned for the West Haven Medical Center is identified in the Five Year Medical Facility Development Plan which was reported to the Congress last summer as planned for fiscal year 1993. The project is, however, being developed to permit its consideration during the preparation of the FY 1992 budget in keeping with the practice of preparing a few additional projects for each budget year to be available in the event other projects are not ready for inclusion in the budget.

As you are aware, a Facility Development Plan (FDP) has been initiated at the Medical Center. It had been the Department's intention to complete the FDP through selection of a strategy prior to beginning the specific project development. This approach would begin advance planning in FY 1989 and was scheduled to take place in a time frame consistent with budget readiness for FY 1992. Recently however, the Department's Office of Facilities working with the Medical Center concluded that while possible, the schedule was very tight and could not be met if any delays were incurred. Therefore, it has been decided to carry out advance planning for the project concurrently with the FDP activities. This will begin advance planning for the project in the very near future and ensure that the project is fully developed and available for inclusion in the FY 1992 budget, if priorities and available resources permit. The Director of the Medical Center was apprised of the decision on March 16, 1989, and has expressed his support for this approach.

Your concern for the welfare of veterans and quality of health care is one which I fully share.

Sincerely yours,

Edward J. Derwinski
Edward J. Derwinski
Secretary

"America is #1—Thanks to our Veterans"

STATEMENT OF DR. PHILIP K. BONDY,CHIEF OF STAFF WEST HAVEN VA MEDICAL CENTER

My name is Dr. Philip K. Bondy. I am Chief of Staff of the West Haven VA Medical Center and Associate Dean for Veterans Affairs at Yale University School of Medicine. I graduated from Harvard Medical School in 1942, am certified in Internal Medicine, and have made Endocrinology and the endocrine aspects of cancer my major field of clinical interest. I have been a member of the faculty of the Yale University School of Medicine from July, 1952 to the present, except for July, 1972 - December, 1977, when I was Professor of Medicine at the Institute of Cancer Research in London, England.

My major concern today is the problem of recruiting and retaining qualified staff at West Haven.

We can recruit physicians only because of the prestige of Yale and because Yale supplements our physicians salaries. This is becoming less workable as our physician salaries in some specialties fall to less than half the going wage.

The problems in recruiting nurses, pharmacists and other clinicians have been temporarily eased by special pay rates but our salary scale interferes seriously with recruiting engineering and maintenance specialists, clerks and upper echelon administrators such as service chiefs.

Thus, although we have a high level of clinical competence, there are difficulties in maintaining the function of equipment, obtaining timely responses from the medical record room and appropriate support from many of the administrative services.

Highly trained physicians, dentists and nurses spend an unreasonable amount of time doing clerical chores and running errands. This is an expensive waste of talent and it prevents clinicians from spending as much time on patient care.

TESTIMONY FOR JOSEPH M. RUSSO, CHIEF, MEDICAL ADMINISTRATION SERVICE
WEST HAVEN, CONNECTICUT
MAY, 15 1989

- Good Afternoon! My name is Joseph Russo and I am the Chief, Medical Administration Service. I am responsible for, among other things, providing clerical support to physicians and nurses, and maintaining the quality of medical records. My Service is also having problems recruiting and retaining personnel.

- As any major hospital accreditation organization will attest; the single most influential factor in the provision of **quality** health care, is the existence and maintenance of a well documented medical record. At West Haven we pay file clerks, the employees responsible for performing hands-on maintenance and delivery of this very important medical record, $13,531/year (or about $6.50/hour). Incidently, this is about $.50 more per hour than the rest of the VA because we have special pay rates for clerical positions in the GS-1 through 6 grades.

- For $6.50/hour we require an average file clerk to file approximately 160 medical records and 440 pieces of loose filing, answer about 30 phone calls, search for 10 to 15 lost or missing records, and make one or two deliveries of medical records during an eight hour day. All of this is done while standing (or walking) in a dusty, crowded, windowless environment. To put this in perspective; in an 8 hour day with **no** time allowed for breaks or visits to the rest room, a file clerk must access a medical record, and ensure that nothing gets misfiled or misplaced, while answering telephone calls, every 48 seconds. For this day, he or she will get paid the staggering sum of $52.00. Meanwhile, at a local super market, where your groceries are guaranteed to be in good health, high school students, who need not even know how to run a cash register or make change (laser beams and computers do it all), make $7.95/hour.

- At West Haven, during the last twelve months, we experienced a 288% turn-over rate in file room employees. In spite of the fact that these employees are getting special pay rates, the majority left the VA for less responsible albeit higher paying jobs in the community.- Special pay does not solve this problem and therefore, does not work.

TESTIMONY OF KENNETH A. VEYSEY
PRESIDENT, A.F.G.E. LOCAL 1674
DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER
WEST HAVEN, CT.

Good Afternoon, my name is Kenneth Veysey, President of the local, AFGE. I represent over 700 federal employees in this hospital and the Regional Office in Hartford.

My testimony concentrates on the severe pay inequities that are directly related to the recruitment and retention problem at this hospital. These inequities are not isolated to just the gap between Federal and Private Sectors in Connecticut, but also within the entire VA system.

We are unable to retain qualified people right within the VA system due to the multitude of VA Hospitals around the country offering lower cost of living areas with attractive pay raises for the exact same job.

It is also difficult to recruit and retain people from private sector employers who can offer significantly higher salaries and better benefit packages.

A classic example of this is with the only elevator mechanic at this hospital. Last year he attained his State License for elevator repair. The VA System could not allow this man a competitive wage. Subsequently, he went to a private sector employer with more than an 80% pay raise, fully paid health benefits, and a dental plan. The real absurdity here is, he now works 2 to 3 days a week here at this hospital on the exact same elevators as an outside contractor.

This not only costs the taxpayers significantly more a year on this one salary alone, but it is one of the many examples of how the veteran is inconvenienced by not having the benefit of sufficient, full time, qualified employees for adequate health care services.

Thank You for this opportunity, I will be happy to answer any questions.

STATEMENT OF
PAUL ERRERA, M.D.
DIRECTOR, MENTAL HEALTH
AND BEHAVIORAL SCIENCES SERVICE
VA CENTRAL OFFICE
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

MAY 15, 1989

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to report on the VA's Homeless Chronically Mentally Ill (HCMI) Veterans Program. This program was started in 1987 by authority granted in Public Law 100-6 and was extended by Public Law 100-71. Currently, under Public Law 100-322, the HCMI Program is authorized to continue through September 30, 1989 and, legislation has recently been introduced (S. 405) to extend this program for an additional three years. Also, authority to appropriate $15 million for the HCMI Program in FY 1990 has been provided through the Stewart B. McKinney Homeless Assistance Amendment Act of 1988, Public Law 100-628. For FY 1989, the Veterans Health Services and Research Administration (VHS&RA) has supported this program with $13.252 million from the VA's medical care appropriation.

The VA's HCMI Programs have been established at 43 VA medical care facilities located in 26 states and the District of Columbia. While the HCMI programs may vary slightly from site to site, each program provides outreach and case management services, initial assessments as well as full medical and psychiatric examinations, linkages to community services and programs, and, when appropriate, placement in community-based psychiatric residential treatment facilities for care and rehabilitation. In the first 11 months of the Program's operation, over 10,500 homeless veterans had received an initial assessment and approximately 2,124 HCMI veterans had been placed in 184 community-based residential facilities.

Program evaluation and monitoring are integral components of the HCMI Program. Dr. Robert Rosenheck, Director of the Northeast Program Evaluation Center (NEPEC) at VAMC West Haven developed and implemented this evaluation and through it we have gained detailed information about the veterans served by the program and the types of services provided to the veterans. We are also just beginning to analyze the information about patient outcome following treatment in the HCMI Program. Data from this evaluation indicate that the HCMI program is reaching it target population: profoundly poor, homeless veterans with chronic psychiatric disorders. Preliminary data from the outcome component of the evaluation indicates that over half of the veterans who become engaged in the program have been successful in meeting some treatment goals. The remaining half of the veterans had less constructive involvement with the program because they did not want help or because their psychopathology made it difficult for them to use the help offered by the program.

STATEMENT OF

ROBERT ROSENHECK, M.D.

DIRECTOR, NORTHEAST PROGRAM

EVALUATION CENTER (NEPEC)

VA MEDICAL CENTER WEST HAVEN

Mr. Chairman and Members of the Subcommittee:

It is a pleasure to appear before you today to provide you with information about the Northeast Program Evaluation Center (NEPEC) and some of its projects.

The VA has experienced and continues to experience a major transition in its delivery of mental health services. NEPEC was asked to assess this transition and, in order to fulfill the reporting requirements contained in Section 114 of Public Law 100-322, NEPEC was asked to study and evaluate the impact of the Resource Allocation Model (RAM) on the VA's delivery of psychiatric care. Among other things, NEPEC was able to point out a 36% decrease in the Average Length of Stay for psychiatric patients and a substantial increase in readmission rates for patients with psychiatric diagnoses in the years following implementation of the RAM.

Dr. Errera has provided you with a brief overview of the VA's Homeless Chronically Mentally Ill (HCMI) Veterans Program. The VA has also established the Domiciliary Care for Homeless Veterans (DCHV) Program through authority provided by Public Law 100-71. Both of these programs represent special programmatic efforts to engage veterans who are in great need of health care and rehabilitation services and have made little use of VA services. NEPEC was given the responsibility to evaluate both of these programs and provide Congress with the results of these evaluations in accordance with requirements set forth in Public Law 100-322. These evaluations have shown that the VA's programs for homeless veterans have been successful in reaching their intended populations. The evaluations have provided the VA with extensive data about the homeless veteran population and these evaluations will continue in order to determine treatment outcome and assess the cost effectivness of these programs.

NEPEC has also been responsible for assisting the Regional Director, Northeastern Region in developing, implementing and evaluating the Region I Mental Health Initiatives Project. This project has been implemented at eleven VA medical centers in the region and is designed to work intensively with psychiatric patients who are high hospital users in order to provide them with specialized services. The evaluation of this demonstration project has been designed to assess the impact of these specialized services on the veterans' utilization of inpatient services and provide continuous monitors of their health status.

By monitoring the patterns and costs of mental health care throughout the VA system and by gathering data on the VA's innovative mental health programs, NEPEC is serving as a center for identifying optimal directions for future mental health care delivery.

TO: Committee on Veterans Affairs - G.V. (Sonny) Montgomery, Chairman

FROM: James M. Hill

RE: Homeless Veterans

DATE: May 15, 1989

I am here today to ask your help in resolving a National tragedy - homelessness among Vietnam Veterans. This problem has been identified, without question, as real. Now we must pool our resources to find a solution.

Approximately, 30 to 40 percent of the homeless in this country are veterans who served to protect the dignity of people and they are losing theirs.

By remaining silent or just applying a band-aid, we are contributing to this growing problem, and we are doing a disservice to those men and women who sacrificed so much. To ask them to give of their lives and not assist them in meeting the basic needs of life is , in my opinion, criminal.

A tremendous number of Vietnam Veterans, some estimates show 600,000, suffer from some form of Post Traumatic Stress Disorder (PTSD) which can lead to substance abuse and ultimately a break-up of the family. This is attributed to be a frequent cause of homelessness.

There has to be an aggressive approach to the treatment of PTSD. More funds have to be allocated to reach these people through programs and facilities that not only offer hope but achieve results.

Mental illness has been recognized as one of the leading causes of homelessness among veterans and others, and yet, we have no reliable estimate of the number of mentally ill on the streets.

Hearings held in mid-1988 revealed that the VA, because of its financial situation could not afford to help all the veterans with medical problems. Accessible medical care has to be addressed because short and long term medical problems that are not resolved can lead to job loss and as a result, homelessness.

Without good numbers, you in Congress are not able to allocate funds in an effective manner. Funds have to be allocated and programs established that will, not only, provide shelter and medical help, but also on-going follow ups to ensure long term positive results.

I ask you to assist us in providing a quality of life that these valiant men and women, not only need, but deserve. They paid a tremendous price and it is our turn to repay the debt we owe.

Vietnam Veterans organizations around the United States are working to reach these veterans through various means. I belong to Chapter 251 of Vietnam Veterans of America here in Connecticut and we have committed ourselves to identifying the magnitude of the problem in our area and we hope to be able to help in any way we can.

We cannot solve the problem alone through scattered programs. We need your help.

Thank you for this opportunity to be here today and I look forward to working with you in reaching a positive solution to this epidemic.

Myron Genel, M.D.
Associate Dean
YALE UNIVERSITY SCHOOL OF MEDICINE
OFFICE OF GOVERNMENT AND COMMUNITY AFFAIRS

Thank you for the opportunity to speak to you this afternoon. I am Myron Genel, a physician and member of the faculty of the Yale School of Medicine since 1971. I am currently an associate dean with primary responsibility for government and community affairs. These duties have brought me in close contact with the VA Medical Center, frequently as the Dean's representative. In addition, I have recently served as chairman of the search committee for a new chief of staff, to replace Dr. Bondy who is retiring in July. Thus I feel that I have an intimate familiarity with the West Haven facility and its programs.

The West Haven VA has been closely affiliated with the Yale School of Medicine from the days that it opened little more than 35 years ago, in 1953, after the present buildings were constructed. Together with the Yale-New Haven Hospital, the West Haven VA Medical Center is a major teaching affiliate of the School of Medicine and is an important component of our tripartite mission of teaching, research and clinical care. In recent years, under the leadership of Dean Leon E. Rosenberg, the school's commitment to this affiliation has been reaffirmed and strengthened.

Let me cite a few examples. First, when Dr. Stephen Waxman was recruited for the chairmanship of neurology three years ago, it was decided to construct the additional necessary laboratory space required on the VA Medical Center campus. Out of that evolved what is now the PVA/EPVA Center for Neuroscience and Regeneration Research, dedicated precisely one year ago. The chairman of this committee, Congressman Sonny Montgomery, was the keynote speaker at these dedication ceremonies. Second, arrangements have been completed recently for construction of a PET scanning facility at the VA using a combination of VA and private funding. This new center will represent a major institutional resource, the only such facility available between New York and Boston, and a major resource for clinical investigators at the School of Medicine. Third, the medical school's academic departments with significant involvement at the VA have likewise made major commitments by identifying as service chiefs, and for other major VA positions, some of the most highly regarded and promising members of our faculty, such as the service chiefs who accompany me on this panel, Drs. Charney, Rastegar and Soufer.

Precisely because of these commitments, last fall Dean Rosenberg wrote a now widely circulated and often quoted letter which was sent to members of the Connecticut congressional delegation and to leadership of the congressional appropriations and veterans affairs committees. In this letter, the Dean expressed concern that chronic underfunding of the VA medical care system was drastically eroding the quality of care, and thus the educational experience, provided our medical students and residents. If you permit me, I would like to quote from that letter:

> "As the funding for VA hospitals has slowly been eroded, the difference in quality of care provided at university and community hospitals on the one hand, and the VA on the other, has become more marked. We do not yet have a two tier health-care system as reflected in the quality of the physician and nurse care received by our veterans. It does appear, however, that veterans are receiving inferior care as measured by the availabililty of ancillary support, the age and sophistication of equipment, the physical plant, and the lack of secretarial and clerical coverage. These deficits force already overstretched physicians and nurses to take time from patient care responsibilities to do things for the patient which at other institutions are performed by less expensive, more easily recruitable staff.
>
> Please understand that these comments are not a threat to disaffiliate from the VA. Rather, they reflect a very reluctant realization on our part that we cannot allow our students and medical residents to participate in part of their training in an institution which is becoming substandard. If deterioration of the system is permitted to reach a level requiring disaffiliation, there would be a tragic loss of a major resource in American medicine."

This committee has been extremely responsive to these concerns and we are very grateful. In particular, we salute your recent recommendation for a supplemental FY89 appropriations of $432 million, though we are aware that the final figure approved by the full appropriations committee was less, $340.1 million, and, as of this date, has yet to be acted upon by the full House.

Further we fully support the committee's recommendation for a $1.3 billion increase to that initially requested for VA health programs in the administration's FY90 budget proposal. Dean Rosenberg and other members of our faculty have recently written to members of Congress urging adoption of these numbers. As stated in Dean Rosenberg's letter to the Appropriations Subcommittee on March 23:

> "The VA health care system has been a unique and heretofore exemplary model which has proven successful in providing our veterans access to the highest quality medical care while concurrently contributing a valuable setting for medical education and a site for clinical research of benefit to the entire nation. This is a delicate montage which is in danger of coming apart unless adequate support is restored by Congress."

In this formal statement I have chosen not to itemize a long list of problems which, in our view, derive from insufficient funds. I will leave that to those in the trenches, such as my colleagues on this panel. However, allow me to close by relating a personal vingette. Thirty years ago, while a junior medical student at the University of Pennsylvania just beginning my clinical experience, my initial medicine rotation was split between the medical services at the university hospital and that at the nearby municipal hospital, the old Philadelphia General Hospital or PGH. There was an appalling gap between the services and facilities at the two institutions and I still remember what a totally depressing and discouraging experience it was for a young, perhaps naive, and idealistic medical student. Recognizing the massive deficiencies, the City of Philadelphia closed PGH and tore down the buildings a few years later. I regret to say that I see many elements of the old PGH rising in our Veterans' Hospital. I urge you to do all within your power to permit the West Haven Veterans Hospital to again become a premier academic medical center, not another PGH.

TESTIMONY OF DR. ASGHAR RASTEGAR, CHIEF, MEDICAL SERVICE
VA MEDICAL CENTER, WEST HAVEN, CT

I am Asghar Rastegar, Chief of the Medical Services at the West Haven VA Medical Center and Professor of Medicine at Yale School of Medicine. I am an attending physician in this hospital as well as Yale-New Haven Hospital. As a clinician/administrator I am disturbed when I see that highly trained professionals (physicians, nurses, technologists, etc.) are forced to do clerical work because this medical center is not competitive enough to attract qualified individuals for these tasks. The most common complaint I hear from young physicians-in-training, as well as nurses, is lack of adequate infrastructural support.

As the chief of a clinical service I see the ever increasing gap in salary between the VA physicians and those at the university hospitals (a gap that in certain specialties approaches 100% of the salary), as an important impediment to the recruitment and retention of excellent clinicians. Although we continue to provide high quality care to our patients, these issues, unless resolved, will result in deterioration of the working environment in this hospital and eventual departure of valuable personnel.

TESTIMONY FOR ROBERT SOUFER, M.D., CHIEF, NUCLEAR MEDICINE SERVICE
VA MEDICAL CENTER, WEST HAVEN, CONNECTICUT
May 15, 1989

My name is Dr. Robert Soufer. I have been the Director of General and Cardiovascular Nuclear Medicine at the West Haven VA since 1985. This is coterminous with my appointment as Assistant Professor of Diagnostic Radiology and Internal Medicine at the Yale University School of Medicine.

I graduated medical school in 1978 from New York Medical College and have trained in internal medicine, cardiology, and nuclear medicine at Downstate Medical Center/Brooklyn VA, Manhattan VA, and at Yale University. My committment in the health care system has been almost exclusively in the city hospital system, and in government service in the VA medical system.

I consider the deliverance of health care in the municipal and government arena commensurate with the highest goals a physician can pursue. Based on my experience in the above-mentioned hospitals, West Haven VA is unique in many aspects. The combined talent of the physicians at this hospital which is a direct result of our close affiliation with Yale University is unique in my experience, and affords our veterans the highest attainable level of care. However, there are certain trends that are presently and immediately threatening our high level of patient care.

1. The salary structure, and the performance standards which determine various GS grades from the technician to the physician level are inflexible and not current. We are in a position where we can only recruit the most committed people in supervisory and higher leadership positions who are willing to sacrifice economic gain for government service. These leaders are unable to recruit the appropriate infrastructure of loyal and high quality people to deal with the day-to-day operation of what is needed to deliver smooth health care. An example comes to mind of one of my most trusted employees who I recruited from Texas who could not afford housing in Connecticut, even with a $5,000 salary increase, I once found him late at night mopping a floor at a convenience store just to make ends meet. The salary structure on the physician level is not on par on the associate and full professor rank which perpetuates a situation where only the very junior of faculty or the very senior of faculty who are declining in their services and pay would be attracted to our VA system.

2. We have displayed leadership in many medical fields at this VA (which is a direct result of its Yale affiliation) in the areas of Virology, Epilepsy, Liver Disease, Infectious Diseases, and Cardiovascular Nuclear Medicine. This level of sophistication confers tertiary and primary care coexistence. However, the accountability and reward systems in our bureaucratic process does not necessarily allow for this level of sophistication. One example of this is our Cardiovascular Nuclear Medicine Department which performs complex assessments of heart relaxation which are clinically useful for a therapeutic algorithms in patients with heart failure. Although we perform 6,000 exams with half the number of technologists as Yale, our technologists must work with standby pay just to make their pays equivalent with the Yale techs with no on-call, they must work on old and antiquated equipment. These issues make daily life at the West Haven VA very frustrating.

3. Then why do we stay despite these circumstances? The reason I stay is because of the patients. The patients need an advocate and deserve the highest level of care commensurate with the level of care of an affluent patient who presents themselves to the Yale-New Haven Emergency Room. We deliver that care, but under continual frustration, and at times neglect by the bureaucracy. We are here because the veterans need us and I appreciate that need.

TESTIMONY FOR DENNIS CHARNEY, M.D.
CHIEF OF PSYCHIATRY
VA MEDICAL CENTER
WEST HAVEN, CONNECTICUT
May 15, 1989

These remarks are designed to reflect my commitment to providing top quality care to our Veterans. I speak to you as a physician with clinical experience in a wide variety of treatment settings including university, state, federal, private and not for profit facilities. In particular, I wish to point out that I and my psychiatric colleagues at the VA are strongly affiliated with the Yale University School of Medicine. This affiliation, in my opinion, has been of enormous benefit to both the West Haven VA Medical Center and Yale University. The VA provides an exciting and rich environment to treat patients, educate students and conduct research to further increase our knowledge of medical and psychiatric diseases. The University provides the VA with doctors and students who are among the best in their profession and routinely work long hours far beyond those that are expected and are paid for. Therefore, I am extremely committed to measures that serve to maintain the vitality of our Yale University affiliation.

Currently, I am concerned about the future of the affiliation and our ability to maintain our current high quality of medical and psychiatric care at the West Haven VA Hospital because of an inadequate salary structure and a decaying physical plant. The salary structure results in the full spectrum of VA employees, from the ward clerk to the physician being paid far below community standards. As a consequence, we have severe difficulty recruiting and retaining qualified, dedicated personnel. This problem adversely affects all aspects of daily patient care from housekeeping to building maintenance, to nursing care, and to physician availability.

Lack of funds and personnel are taking their toll on our hospital.

Personally, I very much enjoy working at this hospital providing Veteran patients the care that they deserve. In order to accomplish this, we must be able to recruit and retain qualified employees.

Testimony Submitted

to

House Veterans Affairs Committee

Subcommittee on Hospitals and Health Care

Department of Veterans Affairs Medical Center

West Haven, CT

Monday, May 15, 1989

Eastern
Paralyzed
Veterans
Association

75-20 Astoria Boulevard
Jackson Heights, NY 11370-1178
(718) 803-3782

Good Afternoon Chairman Morrison, and Ranking Minority Member Rowland. My name is James J. Peters, Executive Director of the Eastern Paralyzed Veterans Association (EPVA). Thank you for the invitation to appear today. EPVA is privileged to have this opportunity today to discuss the effects of budget constraints on the quality of veterans' health care services.

EPVA is a chapter of the Paralyzed Veterans of America (PVA) which is a congressionally chartered veterans's service organization. All of our members have either an injury or disease of the spinal cord. Our membership is located throughout Connecticut, New York, New Jersey and Pennsylvania.

Since World War II there have been tremendous medical advances which have greatly increased the life expectancy of an individual with a spinal cord injury. The development of effective antibiotics have lifted the potential death sentence facing the disabled community. This positive step, has brought on many problems in dealing with quality of care issues.

In our testimony, we will be discussing the Department of Veterans Affairs (DVA) budget, the quality of Veterans Health Care, ideas for improving retention and recruitment, and EPVA's pending lawsuit against Castle Point Veterans Medical Center.

DVA BUDGET

During the past few years the DVA has consistently submitted insufficient requests for funding to the Congress. The process has pushed the DVA into a crisis situation from which it may never recover. The DVA facilities are all suffering from inadequate funding and are being forced to borrow money from other accounts to keep the facility running. This practice has reached epic proportions and now threatens the long term future of the veterans health care system.

The Veterans' Service Organizations have long advocated for adequate funding of veterans medical programs. It was apparent to them that something had to be done to address the Administrations continued practice of submitting inadequate budget proposals to the Congress. Therefore, in response to this growing concern, PVA, along with AMVETS, Disabled American Veterans and the Veterans of Foreign Wars, developed "The Need is Now: An Independent

Budget by Veterans for Veteran's Program." This document has been well received and is becoming an integral part of the budget process.

The Independent Budget takes a hard look at all of the DVA's programs and advocates for money that will just keep the programs running at last years levels. This is a realistic approach in a time of fiscal constraints facing all Americans. However, the inadequate requests for funds each year, has put the DVA in a very difficult position. The increases must exceed the normal increased costs in order to make up for years of shortfalls. The local facilities have run out of "fat" and are facing numerous problems keeping beds open. This situation should not be allowed to continue.

The current Fiscal Year budget is already expected to have a $600 million shortfall. EPVA supports the supplemental appropriation being considered in the House and Senate and which is supported by the White House. Although the supplemental is not enough, it will spare the DVA many hard choices, such as the closing of facilities, eliminating additional beds, or laying off of much needed staff.

It's imperative that the DVA Fiscal Year 1990 Budget include the increases passed in any supplemental appropriations. If it doesn't, the budget will already be facing severe problems before it takes effect, since it will be based on an inaccurate projection of need.

The Independent Budget Proposal calls for an $31.297(B) budget, which would allow the DVA to provide services at last years level. No new programs would be supported and the DVA would have to make do. Unfortunately, the Senate Budget Resolution Outlay is $29.988(B) and the House Budget Resolution is $29.975(B). Both of these figures, if passed, will not provide for adequate funding to ensure that veterans receive, at a minimum, services equal to last years. This continued reduction of service will lead to a further erosion of the care given at DVA facilities and will eventually lead to the dismantling of the current system.

QUALITY OF VETERANS HEALTH CARE

The budget crisis and the fiscal constraints over the last several years have affected the way the DVA delivers health care. The issue of quality of care continues to be on everyone's mind.

In return for service, the nation promised health care to those who served in the armed forces. As a result, one of the largest health care systems in the world was created. Tremendous leaps in medical care and technology have been made in the VA system because of the dedication to research and training. However, today that very system is in a crisis.

EPVA has always made veterans health care our number one priority. The level of deterioration in the DVA system has reached critical levels which are affecting the veteran population each and every day. The crisis demands immediate attention or we will lose a health care system that has always be rated as one of the best in the world.

The DVA's ability to deliver adequate medical services to our nation's veterans has slowly but steadily deteriorated. Shortages of critical medical services are being felt throughout the VA's medical system.

EPVA, as well as individuals in the DVA health care system, are convinced that the system is losing its control over the quality of care it is delivering. Several indicators related to quality lead us to this conclusion. They include staff shortages, recruitment and retention problems, lack of funds to purchase such medical devices as artificial joints, unwarranted delays in the purchase of prosthetics and medical equipment such as wheelchairs, and increasing amounts of nursing overtime.

The DVA continues to deny care to non-service connected veterans with a more restrictive use of the "obviate the need" criteria. This can only cause more serious and costly problems to occur by delaying treatment and force a much longer hospitalization once the veteran is finally admitted for care.

A burgeoning backlog of medical equipment replacement needs, continues to grow. Many facilities continue to use discretionary funds to support nondiscretionary reoccurring base requirements. Reductions to staff in such critical supporting areas as prosthetics and building maintenance have all contributed to the decline of quality. These indicators are present across the system and have been substantiated through evidence accumulated by PVA during the past year, much of which was made available to the House and Senate Veterans' Affairs Committees at their hearings on the VA "Shortfall" (September 7 and 9, 1988).

DVA Medical Centers (DVAMCs) with spinal cord injury (SCI) units, such as Castle Point and Bronx, New York and East Orange, NJ are facing many serious problems. The demand for SCI unit services is tremendous. We have found that SCI units are cutting back services, because of lack of funding and staff. In some cases, DVAMC's are eliminating the number of available beds in the SCI units, while veterans are being placed on waiting lists. These beds are eliminated in violation of Congressional mandates. The funding originally allocated for these beds, which as you already know, are referred to as "phantom beds", is then spent on operating funds. These beds exist only on paper. Because of severe staff shortages caused by critical system-wide funding shortfalls, they are not providing necessary medical care.

Inadequate funding levels have ravaged the VA's ability to maintain bed levels, staffing levels, and timeliness in the provision of essential medical services. The shortage of staff at DVAMC's is increasing pressure on existing staff, thus multiplying their workload to unmanageable levels. Dangerous situation for patients are being created because of the staff's inability to spend adequate time with each patient in providing them with the proper medical care.

Recruitment and Retention

The staffing at DVAMC's is becoming another serious problem. There is a nationwide shortage in nursing and demand continues to grow. The DVA's efforts have produced minimal results since the lack of authority to be competitive restricts efforts to recruit and retain DVA nurses. Resolution of this problem must be given a top priority. Legislation to address this concern has been introduced by the Chairman of the House Veteran's Affairs Committee, Sonny Montgomery and Representative Kennedy.

The "Veterans' Health Care Programs Amendment of 1989", HR-901 sponsored by Chairman Montgomery would significantly improve the DVAs' ability to recruit and retain nurses and other "hands on" health care personnel. The provisions included in this legislation would go a long way in relieving the critical shortages being experienced by DVAMC's in these important health-care fields.

There are two sections of the bill that we would like to discuss.

SECTION 101 SPECIAL PAY FOR NURSES

EPVA supports and firmly believes that the incorporation of "special pay for nurses" is critical in the overall enhancement of the nursing program. DVA can only attract and retain these individuals if they are properly compensated for their expertise and special abilities. By addressing such issues as tenure, overtime, professional expertise, and other special attributes, you have properly included these individuals in the "highly qualified" category along with physicians and dentists.

SECTION 102 PREMIUM PAY FOR LICENSED PRACTICAL OR VOCATIONAL NURSES AND NURSES ASSISTANTS.

EPVA supports this section, which would enhance compensation for licensed practical and vocational nurses and nurse assistants. These professionals would then be appropriately elevated to a level of premium pay which would truly reflect their worth. The importance of trained and qualified nurses' assistants cannot be understated. They are at the core of providing much needed services to spinal cord injured veterans. This is an extremely difficult job and appropriate pay is necessary to keep these individuals adequately compensated.

DVAMC's must be able to compete with private-sector hospitals if they are to get a fair share of the ever-dwindling pool of health-care personnel.

The second bill to address the issue of recruitment and retention is the "Veterans Nurse Pay Act of 1989", HR-119, sponsored by Representative Kennedy.

EPVA supports the provisions contained in HR 1199. This bill, in conjunction with HR 901, provides meaningful incentives that encourage the recruitment and retention of nurses. It also enhances the potential for career opportunities while recognizing "time-in-grade" longevity of the professional health care personnel.

Especially important is the provision for inclusion of geographic cost-of-living pay differentials. This provision is especially important for DVA facilities in our area. These DVAMC's are facing an uphill battle in recruiting and retaining nurses, because of the higher cost of living.

EPVA strongly endorses both initiatives in H.R. 901 and HR 1199. They make much needed improvements to enhance DVA recruitment opportunities in the areas of nursing and other medical personnel.

EPVA LAW SUIT

The budget constraints and the breakdown in providing quality of care has taken its toll on everyone. *Extreme frustration* over the poor patient care at the Castle Point Veterans Administration Medical Center in Wappingers Falls, New York forced EPVA to file a lawsuit against the DVA. We have been forced to seek judicial assistance in order to ensure that spinal cord injured patients at Castle Point receive adequate care. The administration at Castle Point is aware that we are unsatisfied with the care and treatment provided to spinal cord injured veterans at the spinal cord injury center. Despite this knowledge, the administration has done little to improve conditions.

We conducted our own survey of the inpatients at the Medical Center and directly observed and identified problems at the Castle Point DVAMC, which must be remedied. These include, but are not limited to, the following:

- The supply service, as opposed to the medical professionals, dictates the availability of certain supplies, such as indwelling and condom type catheters. These decisions are, therefore, based on financial rather than medical criteria.
- Patients receive bowel care in bed. This is degrading since other patients find it offensive and make insulting remarks. This practice retards rather than furthers the rehabilitation of the SCI patient.
- The availability of baths and showers is extremely limited, due to staff shortages.
- Physical, occupational, corrective, and educational therapies, as well as driver training, are not provided at levels sufficient to meet patient needs.
- The Castle Point VAMC delays transfer of SCI patients for annual examinations and/or other care because it has closed down SCI beds, due to lack of staff.

It is apparent to EPVA that other SCI centers afford better treatment to SCI patients than is afforded at the Castle Point DVAMC. Attempting to use the law to remedy this disparity of treatment presents EPVA with a problem unique to organizations and individuals seeking to sue the DVA. Even though the DVA is a creature of statute and subject to the laws of the United States, veterans do not have the ability to seek judicial relief when they are aggrieved by DVA action, at least insofar as enforcing Title 38 of the United States Code, the law that directly affects the DVA. The DVA adopts regulations to implement the congressional mandates expressed in Title 38. A portion of the Title 38 regulations is called the "The Patient's Bill of Rights." Even though the DVA has afforded patients' rights, and has specified what they are in the Title 38 regulations, the laws of the United States prohibit veterans from using these regulations affirmatively to seek relief in the courts.

Therefore, EPVA will make claims based on laws other than those contained in Title 38 of the United States Code, or the Code of Federal Regulations. Since the DVA is a department of the federal government, the Fifth and Fourteenth Amendments of the United States Constitution provide EPVA with a basis for litigation. When the VA denies or withholds from a veteran a benefit or service, or treats certain veterans in a disparate manner, it does so under "color of law." These actions violate the due process and equal protection clauses of the Fifth and Fourteenth Amendments. As a federal department, the VA is subject to constitutional claims.

EPVA has reluctantly taken legal action against the DVA to remedy the current situation at Castle Point. EPVA's primary objective is the provision of quality care and treatment for those with spinal cord injuries. EPVA could not tolerate the hospital's neglect of patients' needs and disregard of patients' rights. To do so would simply invite further abuse.

It has always been EPVA's belief that the DVA spinal cord injury units provide the best spinal cord injury care in the nation. In order to maintain the quality of care that spinal cord injured veterans treated at Castle Point deserve, EPVA has taken legal steps to force the DVA to improve conditions.

EPVA has a major commitment to ensure that all veterans receive quality health care. As stated above, we are greatly concerned over the deteriorating conditions in services and supports at DVA medical centers. It's not enough to just sit back and wait for change. The following illustrates our commitment, by describing some of our activities aimed to ensuring quality health care in the DVA:

- Recently dedicated at Yale/West Haven, a new Neuroscience Center which focuses on the ways in which the nervous system adaptively responds to injury. Our $750,000 commitment is aimed at bringing about a cure for spinal cord injury and disease.

- At the Castle Point VA Medical Center, we have just funded the construction of a specialized bed service for plastic surgery for spinal cord injured veterans. We have also endowed the New York Medical College, which is affiliated with Castle Point VAMC, in the amount of $500,000 to provide speciality coverage for the Castle Point plastic surgery program. In addition, we annually fund a resident, a fellow and a student from the medical school of function full-time at the Castle Point facility.

- At the Bronx VA Medical Center, we have in the recent past purchased a lithotripter through partial funding of a joint project with the Mount Sinai School of Medicine, amounting to approximately 2 million dollars; we purchased a lasertripter which cost us approximately $200,000; we have endowed the Mount Sinai School of Medicine, which is affiliated with the Bronx VAMC, $500,000 to provide specialty urological coverage for neurourology in spinal cord injury care; we directly fund the services of a fellow in the Spinal Cord Injury Service, a resident in geriatrics, a resident in urology, as well as provide research funding in the area of urology. In addition, we also annually fund a nurses' education program for speciality care through Mount Sinai School of Medicine and, lastly, we have pledged to support 1/6 of the cost of a therapy program to provide therapists to care for the patients at the Bronx VAMC.

- At the East Orange VA Medical Center, we have joined with the New Jersey School of Medicine, Department of Rehabilitation Medicine, to fund the development of a rehabilitation program which includes direct funding of a full-time resident for the spinal cord injury service at the East Orange VAMC.

- In addition to the above direct hospital programs that deliver first hand benefits to our spinal cord injured and deceased members, the Eastern Paralyzed Veterans Association totally funds and operate three organizations: The American Paraplegia

> Society, which is an organization of physicians numbering over 400 medical doctors involved in SCI care; the American Association of Spinal Cord Injury Nurses, which includes a membership of approximately 2,000 nurses involved in full-time SCI care; the American Association of Spinal Cord Injury Psychologists and Social Workers, which includes approximately 500 psychologists and social workers involved in spinal cord injury care. The funding of these organizations includes sponsorship of each member's participation at their annual symposium as well as publication of each organization's journals, educational materials, continuing education programs, peer review, and research programs.

As you can see, we are committed to quality medical care. Because of this commitment to Veterans Health Care, it is totally unacceptable to us to see the deplorable conditions in our hospitals and the deterioration of care.

This concludes our testimony. It was a pleasure being here today to discuss the current problems facing our veterans facilities. If you have questions, I would be more than happy to answer them.

Thank you.

BAVF

Blinded American Veterans Foundation
P.O. Box 65900
Washington, D.C. 20035-5900

May 10, 1989

Mr. G. V. (Sonny) Montgomery, Chairman
Subcommittee on Hospitals and Health Care
Committee on Veterans Affairs
512 Cannon Office Building
Congress of the United States
House of Resentatives
Washington, D.C. 20515

Attention: Congressmen John Rowland/Bruce Morrison, Committee Members

Subject: Financial Status of Blind Rehabilitation Center
Veterans Administration Hospital
West Haven, Connecticut

Dear Mr. Chairman:

The Blind Rehabilitation Center of the VA Hospital, West Haven, serves a regional area covering all the seaboard states from Virginia north, including all the New England states. At present, the Blind Center is understaffed by a minimum of sixteen staff members. All or most of these positions are frozen because of the austerity now existing in this VA Hospital. Because of the current shortage of staff, the Center is not able to rehabilitate blinded veterans as prescribed by the long-standing policies and principles of the Veterans Administration. The original center, the Hines Veterans Administration Medical Center, is currently able to serve thirty veterans at a time with a full program and only minor shortages of staff due to the VA's austerity program.

The current expansion of the West Haven VA Blind Center is causing great stress not only to patients who are getting "blind rehabilitation", but much stress on the part of the staff. At one point, plans were made to give all the fifth floor up for blind rehabilitation. It appears feasible to release this space immediately for blind rehabilitation. Since construction and remodeling of the fifth floor for blind rehabilitation would cause less disruption of a good blind rehabilitation program, it is therefore our recommendation that not only immediate authorization to recruit staff be approved, but the whole fifth floor of Building Two be given over for blind rehabilitation. This will necessitate moving the "alcohol program" from the East Wing as was promised more than six months ago.

There are many current problems here at the Blind Center that reach far beyond just new staff and new quarters. For example, a recent study was just completed that indicates there are problems regarding management, department supervision, and basic philosophy concerning blind rehabilitation in general. The current Chief does not have contact with the blind patients. There have been blind patients leaving this Center without knowing who the Chief is. His staff does not come to him with their problems. After interviewing many of these members, it is my conclusion that they do not go to the Chief because they're afraid of being put down or afraid that what they have to say will be ignored.

At least one supervisor does not offer leadership to her staff and for this reason, most of the staff in that department are completely disillusioned regarding support and other basic essentials needed in the overall picture of blind rehabilitation.

There is a complete document being prepared by members of the Blinded American Veterans Foundation. This report will be available for distribution on or before September 1st. Besides the Center here at West Haven, it will encompass all of the centers and clinics and many of the visual impairment service teams throughout the United States.

The Veterans Administration spent over three million dollars to develop synthetic speech for computers and other items as simple as a talking watch. Due to austerity and many other forces, this equipment is being denied veterans. For example, one service-connected veteran is currently waiting for quipment already approved for more than one year. Prosthetic services need to be reviewed and policies established that will consider prosthetics a major part of the program.

It is strongly recommended that the VIST Coordinator be given the privileges and courtesies of existing Federal law, i.e. secretarial assistance and support in making field visits as described in their job descriptions. Recently, I visited the North Chicago VA Medical Center and found that the VIST Coordinator and other staff members did not even know the basic definition of blindness. The Hines Blind Center, only a few miles away, had never been visited by the VIST Coordinator, nor by the Prosthetics Clerk or any other staff member as far as I could tell. The VIST Coordinator really admitted to me that he was wearing too many hats to be able to give adequate service to blinded veterans, although he knew of some 150 blinded veterans and estimated that there are another 150 additional unknown to him. Currently North Chicago VA Hospital has only a part-time VIST Coordinator and it is strongly recommended that whenever there are enough blinded veterans in any catchment area to warrant a full-time VIST Coordinator, such a Coordinator be assigned. In the case of North Chicago, 300 or more blinded veterans would certainly call for a full-time VIST Coordinator.

On May 17, 18, and 19, I will be visiting the "new" Blind Center at the VA Medical Center in Puerto Rico. I respectfully request that I be able to make a summary of that visit available to the Subcommittee on Hospitals and Health Care.

I have not made comments about the overall financial needs of the VA Medical Center West Haven although we are concerned in the overall sense as the other veterans organizations presenting material here today.

This report is respectfully submitted in hopes that blinded veterans in America will receive the full benefit of blind rehabilitation training and vocational training when appropriate, and leisure activity training. Of course now we who were blinded from World War II are reaching an age where vocational training is not necessarily required due to the age of World War II veterans. For the next twenty to forty years, the emphasis must be placed on leisure activities, although there will be many Viet Nam and Korean veterans who must be given the full measure of total rehabilitation.

Respectfully submitted by:

George "Buck" Gillispie
Director at Large

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MACK FLEMING
STAFF DIRECTOR AND CHIEF COUNSEL

ONE HUNDRED FIRST CONGRESS
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CHAIRMAN

U.S. House of Representatives
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335 CANNON HOUSE OFFICE BUILDING
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June 9, 1989

Honorable John G. Rowland
329 Cannon House Office Bldg.
Washington, D. C. 29515

Dear John:

Thank you for your letter enclosing the information from Mr. George "Buck" Gillispie regarding improvement of the West Haven Department of Veterans Affairs (DVA) Medical Center's Blind Rehabilitation Center.

I will be happy to have this information included in the May 15th Subcommittee on Hospitals and Health Care Hearing Record.

Sincerely yours,

G. V. (SONNY) MONTGOMERY
Chairman

GVM:bpd

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SUBCOMMITTEE ON LEGISLATION

Congress of the United States
House of Representatives
Washington, DC 20515

June 5, 1989

The Honorable G.V. Montgomery
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, D.C. 20515

Dear Sonny:

I am forwarding to you information I requested from George "Buck" Gillispie during the Subcommittee on Hospital and Health Care's May 15th field hearing at the West Haven Department of Veterans Affairs (DVA) Medical Center.

Buck, a blinded veteran from World War II, is the former director of the blind center at West Haven and the former director of blind rehabilitation for the Veterans Administration. As a board member of the Blinded American Veterans Foundation (BAVF), Buck is presently traveling around the country visiting DVA blind centers.

If possible, I would like to have this statement entered in the record of the May 15th field hearing. Thank you for your assistance in this matter.

Sincerely yours,

John G. Rowland

JOHN G. ROWLAND
Member of Congress

JGR/pj

Enclosure

BAVF

Blinded American Veterans Foundation
P.O. Box 65900
Washington, D.C. 20035-5900

May 25, 1989

The Honorable John G. Rowland
Member of Congress
135 Grand Street
Waterbury, Conn. 06701

Dear Congressman Rowland:

In compliance with your request and that of members of the West Haven Veterans Administration Hospital staff, I am sending forth my opinions and recommendations as to what it will take to improve the conditions of and make the Blind Rehabilitation Center of the West Haven VA Hospital function as it was originally intended to and has in the past. These recommendations may seem drastic and in some instances probably are.

Chief of the Center

As I pointed out in my testimony to the Subcommittee on Hospitals and Health Care dated May 10, 1989, the Chief of the Blind Rehabilitation Center, Mr. James Acton, does not have contact with the blind patients and has lost the confidence of many of his staff. At this point, I think that Mr. Acton should step down as Chief and be appointed to a position where his talents could be put to better use. Mr. Acton has a background as instructor in mobility, but it would probably be inappropriate to ask him to return to that posision again.

Communication Department

Miss Carolyn McNair, Supervisor of Communicaton, has almost all of her staff upset and disillusioned regarding support and other basic essentials needed in the overall picture of blind rehabilitation. In addition to staff problems, Miss McNair has allowed her department to become overstocked in storage areas, and her personal work area is completely unacceptable. Miss McNair should be asked to step down and return to being an instruction in the Department, and Mr. Arthur Egan should be promoted to Supervisor of the Department.

Mr. Egan knows well the problems within the Department and will need support when and if he assumes this responsibility. Straightening out the supply area and the cluttered desk area will need to be closely supervised. His major problem will be working with his staff, those who tend to doze off and sleep occasionally, and finding an appropriate place for Joe who stutters. Patients have continually complained about not being able to understand him, and when he gets nervous valuable classtime is wasted since he has to keep repeating himself to be understood. If Joe cannot get his stuttering under control, it may well be necessary to transfer him to an area where he doesn't have contact with blind students for instruction. I'm sure Mr. Egan will be able to take the

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RESEARCH - REHABILITATION - RE-EMPLOYMENT

appropriate steps to find the right approach to Joe's problem and the other staff problems as well.

Most of the cooking instruction has been done by one Ms. Lu Rifai. She has continually asked for and put in for utensils and necessary equipment to bring the kitchen area up to date, but her requests have been continuously ignored by Miss McNair for what reasons, I have not yet been able to determine. The kitchen is obsolete without even proper ventilation, and my recommendation is that the kitchen area be completely surveyed and brought up to date to meet the current needs.

When Ms. Rifai is out on sick-leave or vacation, proper rotation of staff will need to be put into place. This phase of the Department has been completely ignored by Miss McNair and put on the schedule as Independent Work for the patient. (See section following on Independent Work as it relates to the other departments within the Center.)

Nursing

As there are many diabetics and other severely disabled veterans being trained and treated at the Center, it is necessary to have a very well-trained nursing staff, not only in medicine but as medicine relates to blind rehabilitation. As Nursing has been the only staff on during the weekends, Ms. Carr informs me that they were trying to get to veterans out on the weekend, and it is my opinion that nurses should be familiar with weekend passes as they relate to patients, but not included in the actual recreational activities on the weekends. (See section on Recreational Director.)

Recreational Director

I would recommend that Mr. Gregory Kezorkian, Physical Therapy and Director of Recreation, should be transferred back to being a full-time mobility instructor. He currently is handling physical therapy and recreation. Transferring him back to a full-time mobility instructor will relieve some of the pressure on that department. Mr. Kezorkian has a Masters Degree in mobility instruction.

It is further recommended that a full-time position be established of Director of Recreation. A large majority of the veterans that the Blind Center now deals with are at an age where they are not vocational-minded. Therefore, emphasis should be placed on leisure activities, avocations, hobbies, etc. that blinded people are now at an age to take advantage of. Most newly blinded people are completely at a lost as to how to occupy their time. Through good rehabilitation that the VA system is able and should be delivering, we must have a strong emphasis on leisure time in order for the veteran to go away from this Center feeling good about him or herself.

Whoever becomes the Director of Recreation will need to utilize specially trained volunteers to work with the veterans and to under-

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stand the process that these men are undergoing here at the Blind Center. Understanding is extremely important in order that they don't disrupt the process of rehabilitation.

Low Vision Clinic

Mr. Jim Blair, Head of the Low Vision Clinic, has an extremely important role within blind rehabilitation. Some eighty percent of all blind people have some usable vision. Therefore, what Mr. Blair's department does must be continually monitored as it relates to the overall picture of blind rehabilitation. What his staff does and says to and with blinded veterans must be geared to the overall need of the blinded veteran.

Occasionally, the blinded veteran may be asked to use a blindfold with his mobility and manual skills work, and also in other departments. The Low Vision Department always will be able to show the veteran that wearing a blindfold isn't scaring them with blindness, but showing him or her the need to improve his or her tactual or mobility training and to build confidence in these two very important areas.

It is strongly recommended that as many low vision aids (i.e., magnifiers, telescopic lenses, special lighting, etc.) as possible be kept on hand in the Low Vision Department in order to have the appropriate aid or prescription available to avoid the long delay in supplying these special aids. It is always best when the veteran receive training with these aids prior to leaving the Center.

Mobility

The Mobility Department currently is attempting to teach mobility to some twenty patients and there are only three instructors, including the supervisor, Mr. D'Andrea. Mr. D'Andrea needs a minimum of six instructors to do an adequate job for twenty patients. If he does not get help and staff, blind veterans will continue leaving this Center without adequate mobility training. It is recommended that a vigorous recruiting plan be developed and those instructors that are currently doing their best be upgraded from a Grade 9 in order that future instructors coming on the staff will have an incentive to chose the VA as their place of employment. I understand that Central Office has authorization to upgrade staff members doing exceptional work.

Included in the recruiting should be a good outline of what the Center will be like when the proposed construction is completed. Working conditions as they presently exist are substandard, but I'm sure that with completion of the new construction this will be corrected. Any employee coming on should be aware of this.

One of the reasons for the difficulty for attracting mobility instructors is simply that there are only a minimal number of schools graduating

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mobility instructors and all these instructors can chose to work where there are the best salaries, working conditions and benefits.

Manual Skills Shop

The Manual Skills Department, headed by Marty Snitkin, has himself as supervisor and two instructors. They cannot give the time for full-detailed instruction as should be done in this department. Unlike mobility, recruiting for this department should be easier in that these instructors can be taken from several different types of backgrounds. Any employee coming into this department must be trained in special skills, after being hired, needed to teach the blind. Therefore, I have suggested to Mr. Snitkin that he develop a recruiting plan that will be attractive to any and all candidates with the appropriate background.

Independent Work

The social worker, Dave Robinson,and psychologist, Dr. Needham, have attempted to fill in the gap with group sessions, counseling, and whatever other means they can develop to prevent the patient/student from becoming bored and discouraged. Patients, for some time now, have been complaining about boredom and especially IWs (Independent Work).

Blind rehabilitation as longstanding prescribed by the VA is therapy in action. New patients and many of those witn longer time in the Center must have supervised instruction in order to overcome the problems of blindness. It is recommended that IWs be abandoned from the work schedule and whatever activity the patients are having be supervised. There are patients leaving the Center complaining of too much leisure time, i.e. IW the major complaint. There has been a continual flow of patients complaining of staff members dozing, stuttering, and fighting among themselves.

To revitalize this Blind Center, it is necessary to have a strong individual as Chief knowledgeable in blind rehabilitation. For the recruitment of this individual it is recommended that the Director of Blind Rehabilitation Central Office be consulted and approve of any individual who wants the position and is willing to face the task ahead.

Community Resources

It is further recommended that the new Chief develop a rapport with the State and private resources for the blind as there are many benefits that can assist the patients at the West Haven VA as they do throughout country.

In the past, one at least two occasions, Mr. Acton has asked the State counselors to leave the station. A good rapport will need to be rebuilt with community resources.

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It is recommended that all civilian blind employees of the VA be evaluated by the State for needed equipment to better do their job. This equipment can range from a braille writer or braille watch through to sophisticated talking computers. There were two such blind persons providing equipment from the Board of Education and Services for the Blind in Wethersfield, Connecticut in the past. We must rebuild our rapport with them.

VIST Coordinator

The VIST Coordinator at the VA Hospital West Haven is under the direction of Dr. Cohen, Chief of Ambulatory Care. In contacting the VIST Coordinator as late as yesterday, it was impossible to hold a private conversation with the coordinator and had I been a newly blinded veteran this would have been stressful.

By any work standard measurements, all VIST Coordinators, whether blind or sighted need a full-time secretary and/or assistant. The patient load is continually growing as newly blinded veterans come into the field of blindness everyday. The VIST Coordinator needs a room where private conversations can be held. All VIST Coordinators need access to the computers and secretarial help. They need their office covered while making home visits which are extremely necessary in some cases due to the nature of blindness. They must develop a case identification system within the hospital and work closely with the Prosthetics Aids Department as well as the State Rehabilitation for the Blind. The VIST Coordinator needs to constantly monitor pensions and compensations in order to insure that the veteran receives the appropriate amount of money due to him or her.

Central Office informed me this morning that they were down six VIST Coordinators throughout the country and were hard-pressed to fill the positions. One of the reasons they're leaving is to find better jobs and conditions. We have a good VIST Coordinator now --let's not lose her. The blinded veterans in this nation, who is many cases gave up their vision for their country, deserve a fair shake.

* * * * *

The following recommendation coming at the end of this report is one of the most important recommendations. The entire fifth floor of Building Two should be given over for blind rehabilitation purposes. By having the fifth floor, the Blind Center and Clinic will have sufficient room to deparate the two activities. The Clinic patient always carries dual disabilities -- psychiatric, stroke patient, and health problems in general in addition to blindness. Currently, the close proximity and intermingling of both types of patients is very disrupting to them all and causing much anxiety.

By having the totality of the fifth floor, there would be less disruption when the construction, which may take many years, is going on. They will

- continued -

be able to move easier from east to west and west to east than from floor to floor and in addition it will be their permanent location. Mr. Pete Kukish, supervisor of the Clinic patients, by necessity is having to teach in addition to his other two instructors. There is some tension between his staff and the Center staff. This must be cleared up. It is important that the Clinic be provided with supplies and necessary room to do the appropriate teaching required for these multiple-handicapped veterans.

When the Clinic was brought here from Northampton VA Medical Center, it was to be separated from the Center as a whole. This has not been done and must be done if the Clinic is to survive. It is further recommended that additional recruiting be developed immediately to fill the Clinic's needs. The Center and the Clinic are to have a patient load of some 45 blinded veterans, thirty in the Center and fifteen in the Clinic. There always will be certain overlapping services, but Mr. Kukish and the new Center Chief whoever he may be must work closely together to avoid further conflicts.

In surveying the blind centers throughout the country, it is my intent to improve the services for the blinded veteran, no matter what measures must be taken to achieve this end.

If you feel it necessary, I would be glad to have other people substantiate any of these finds in this report. Also, I would be more than happy to discuss any and all portions with you or the VA staff at any time.

Respectfully submitted:

George [illegible]
Director at Large

cc: Congressman Bruce Morrison
Dr. Norman Browne, Director West Haven VA Medical Center
Ms. Alice Wood, Assoc. Director West Haven VA Medical Center
Dr. Bondy, Chief of Staff, West Haven VA Medical Center
Mr. Donald Garner, Director of Blind Rehabilitation
Mr. John Fales, President, Blinded American Veterans Foundation

BAVF

Blinded American Veterans Foundation
P.O. Box 65900
Washington, D.C. 20035-5900

May 10, 1989

Mr. G. V. (Sonny) Montgomery, Chairman
Subcommittee on Hospitals and Health Care
Committee on Veterans Affairs
512 Cannon Office Building
Congress of the United States
House of Resentatives
Washington, D.C. 20515

Attention: Congressmen John Rowland/Bruce Morrison, Committee Members

Subject: Financial Status of Blind Rehabilitation Center
Veterans Administration Hospital
West Haven, Connecticut

Dear Mr. Chairman:

The Blind Rehabilitation Center of the VA Hospital, West Haven, serves a regional area covering all the seaboard states from Virginia north, including all the New England states. At present, the Blind Center is understaffed by a minimum of sixteen staff members. All or most of these positions are frozen because of the austerity now existing in this VA Hospital. Because of the current shortage of staff, the Center is not able to rehabilitate blinded veterans as prescribed by the long-standing policies and principles of the Veterans Administration. The original center, the Hines Veterans Administration Medical Center, is currently able to serve thirty veterans at a time with a full program and only minor shortages of staff due to the VA's austerity program.

The current expansion of the West Haven VA Blind Center is causing great stress not only to patients who are getting "blind rehabilitation", but much stress on the part of the staff. At one point, plans were made to give all the fifth floor up for blind rehabilitation. It appears feasible to release this space immediately for blind rehabilitation. Since construction and remodeling of the fifth floor for blind rehabilitation would cause less disruption of a good blind rehabilitation program, it is therefore our recommendation that not only immediate authorization to recruit staff be approved, but the whole fifth floor of Building Two be given over for blind rehabilitation. This will necessitate moving the "alcohol program" from the East Wing as was promised more than six months ago.

There are many current problems here at the Blind Center that reach far beyond just new staff and new quarters. For example, a recent study was just completed that indicates there are problems regarding management, department supervision, and basic philosophy concerning blind rehabilitation in general. The current Chief does not have contact with the blind patients. There have been blind patients leaving this Center without knowing who the Chief is. His staff does not come to him with their problems. After interviewing many of these members, it is my conclusion that they do not go to the Chief because they're afraid of being put down or afraid that what they have to say will be ignored.

- contined -

At least one supervisor does not offer leadership to her staff and for this reason, most of the staff in that department are completely disillusioned regarding support and other basic essentials needed in the overall picture of blind rehabilitation.

There is a complete document being prepared by members of the Blinded American Veterans Foundation. This report will be available for distribution on or before September 1st. Besides the Center here at West Haven, it will encompass all of the centers and clinics and many of the visual impairment service teams throughout the United States.

The Veterans Administration spent over three million dollars to develop synthetic speech for computers and other items as simple as a talking watch. Due to austerity and many other forces, this equipment is being denied veterans. For example, one service-connected veteran is currently waiting for equipment already approved for more than one year. Prosthetic services need to be reviewed and policies established that will consider prosthetics a major part of the program.

It is strongly recommended that the VIST Coordinator be given the privileges and courtesies of existing Federal law, i.e. secretarial assistance and support in making field visits as described in their job descriptions. Recently, I visited the North Chicago VA Medical Center and found that the VIST Coordinator and other staff members did not even know the basic definition of blindness. The Hines Blind Center, only a few miles away, had never been visited by the VIST Coordinator, nor by the Prosthetics Clerk or any other staff member as far as I could tell. The VIST Coordinator really admitted to me that he was wearing too many hats to be able to give adequate service to blinded veterans, although he knew of some 150 blinded veterans and estimated that there are another 150 additional unknown to him. Currently North Chicago VA Hospital has only a part-time VIST Coordinator and it is strongly recommended that whenever there are enough blinded veterans in any catchment area to warrant a full-time VIST Coordinator, such a Coordinator be assigned. In the case of North Chicago, 300 or more blinded veterans would certainly call for a full-time VIST Coordinator.

On May 17, 18, and 19, I will be visiting the "new" Blind Center at the VA Medical Center in Puerto Rico. I respectfully request that I be able to make a summary of that visit available to the Subcommittee on Hospitals and Health Care.

I have not made comments about the overall financial needs of the VA Medical Center West Haven although we are concerned in the overall sense as the other veterans organizations presenting material here today.

This report is respectfully submitted in hopes that blinded veterans in America will receive the full benefit of blind rehabilitation training and vocational training when appropriate, and leisure activity training. Of course now we who were blinded from World War II are reaching an age where vocational training is not necessarily required due to the age of World War II veterans. For the next twenty to forty years, the emphasis must be placed on leisure activities, although there will be many Viet Nam and Korean veterans who must be given the full measure of total rehabilitation.

Respectfully submitted by:

George "Buck" Gillispie
Director at Large

COMMITTEE ON VETERANS AFFAIRS

FIELD HEARING - MONDAY, MAY 15, 1989

WEST HAVEN VETERANS ADMINISTRATION MEDICAL CENTER

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE ON VETERANS AFFAIRS, THANK YOU FOR INVITING ME TO APPEAR BEFORE YOU TODAY AND FOR GRANTING ME THIS OPPORTUNITY TO PARTICIPATE IN YOUR DELIBERATIONS ON THE PLANNED REVISED MISSION OF THE FEDERAL DVA FACILITIES IN OUR STATE AND THE IMPACT THOSE REVISIONS MAY HAVE ON THE AVAILABILITY OF HEALTH CARE SERVICES TO THE MORE THAN 400,000 VETERANS NOW LIVING IN CONNECTICUT.

MY NAME IS DAVID MCQUILLAN AND I AM THE COMMANDANT OF THE CONNECTICUT STATE VETERANS HOME AND HOSPITAL IN ROCKY HILL, CONNECTICUT. I ALSO SERVE AS VICE PRESIDENT, REGION I, NATIONAL ASSOCIATION OF STATE VETERANS HOMES AND AS A MEMBER OF THEIR CONGRESSIONAL LIAISON COMMITTEE.

THE CONNECTICUT STATE VETERANS HOME AND HOSPITAL HAS A PROUD TRADITION OF PROVIDING SERVICES TO VETERANS OF THIS STATE. FROM ITS DEDICATION ON JULY 4, 1864, THIS AGENCY HAS EXTENDED A HELPING HAND TO WAR-TIME VETERANS AND THEIR FAMILIES OVER THE PAST 125 YEARS.

SINCE 1888, OUR SERVICES HAVE BEEN SUPPORTED BY A PARTNERSHIP WITH THE FEDERAL GOVERNMENT WHO SHARES WITH US THE COOPERATIVE EFFORT OF DELIVERING COMPREHENSIVE AND CONTINUOUS HEALTH CARE TO VETERANS IN THIS STATE.

ON OUR SPACIOUS GROUNDS IN ROCKY HILL, THE GEOGRAPHIC CENTER OF THE STATE, WE OPERATE A 340-BED JCAHCO-ACCREDITED HOSPITAL AND A 650 BED DOMICILE FUNDED THROUGH JOINT CONTRIBUTIONS FROM THE VETERAN PATIENTS, THE STATE AND THE FEDERAL GOVERNMENT. AS A RESULT OF RECENT STUDIES DIRECTED BY OUR GOVERNOR, WE ARE PLANNING REVISIONS TO OUR MISSION THAT WILL INSURE THE LEVELS OF CARE WE OFFER MEET THE LEGITIMATE NEEDS OF OUR VETERAN POPULATION NOW AND INTO THE NEXT CENTURY.

TRADITIONALLY, WE HAVE RELIED HEAVILY UPON THE TWO FEDERAL DVA MEDICAL CENTERS IN OUR STATE FOR REFERRAL OF VETERAN PATIENTS WHOSE CONDITION EXCEEDS OUR CAPABILITY. INCREASINGLY, WE ARE TURNING TO COMMUNITY HOSPITALS FOR SERVICES NO LONGER AVAILABLE FROM THE FEDERAL VA CENTERS. WE KNOW THAT OUR SUPPORTING CENTERS HAVE EXTENDED THEMSELVES TO ACCOMMODATE THE NEEDS OF OUR PATIENTS. BUT, WHEN THEIR RESOURCES HAVE BEEN REDUCED BY CENTRAL OFFICE DIRECTIVE, THEY ARE COMPELLED TO FOCUS ON INTERNAL NEEDS AND OUR REQUIREMENTS, OF NECESSITY, BECOME SECONDARY.

IN THE HIGHLY COMPETITIVE EFFORT TO FILL VACANCIES FOR HEALTH CARE PROFESSIONALS, WE AND OUR FRIENDS IN THE VAMCS FIND OURSELVES AT A DECIDED DISADVANTAGE AND ON AN UNEVEN PLAYING FIELD WHEN COMPARED TO OUR COLLEAGUES IN THE PRIVATE SECTOR WHOSE FLEXIBILITY AND GENEROUS BUDGETS ENABLE THEM TO OFFER SALARIES AND WORKING CONDITIONS FAR MORE ATTRACTIVE THAN THOSE AVAILABLE IN OUR ORGANIZATION. AS A RESULT, WE STRIVE TO DO MORE WITH LESS AND CONSEQUENTLY DRIVE AWAY OUR GOOD EMPLOYEES TO PRIVATE HOSPITALS WHERE STAFFING RATIOS AND HIGHER PAY MAKE FOR A MUCH MORE REWARDING AND ATTRACTIVE EMPLOYMENT PACKAGE.

AGAIN, MY SINCERE THANKS FOR THIS OPPORTUNITY TO TESTIFY.

CONGRESSIONALLY CHARTERED
American Ex-Prisoners of War, Inc.
NATIONAL HEADQUARTERS ARLINGTON, TEXAS
CONNECTICUT CHAPTER
47 LONG HILL RD • CLINTON, CT 06413

May 10, 1989

Congressman Bruce Morrison
Chairman, Subcommittee on Hospitals and Health Care
New Haven, CT

Dear Congressman Morrison:

Reference Congressman Montgomery's letter of May 10 concerning the May 15 meeting of the subcommittee at the West Haven VA Hospital, the following comments concern my testimony should the sub-committee be interested.

1. Reduction of Veterans Medical Benefits at Connecticut VA hospitals.

a. All veterans have traditionally been guaranteed VA medical care. Why at this time when so many WW II and Korean War veterans are retiring in large numbers, are veterans medical benefits being reduced?

b. Connecticut has the highest average income in the US. The income categories established by the VA should not be the same here as in for instance Missippi. This is not equitable.

c. The priorities established by the Congress in 1981 in P.L. 97-37 "The POW Bill" have recently been changed. POW's want their priority at the VA re-instated. Many former POW's do not have service-connected disabilities, although many who do not should actually have a rating.

2. Need for More POW Training of POW Physician Co-ordinators and Rating Boards.

It is apparent to me that some former POW's are having poor success in pursuing compensation claims with the VA. The reason is that the physicians appointed are not fully indoctrinated in POW illnesses. The VA raters look in vain for physicians statements that the veteran has an ailment that may be related to his POW incarceration. I also feel that the VA raters should receive thorough POW medical problem training. Reasonable doubt as a VA doctrine is not being exercised by the rater or the physician. The intent of Congress in PL 97-37 is not being carried out for the POW when he appears for a rating decision.

3. Veterans Records at Medical Facilities.

Some POW's and other veterans when pursuing their claims are handcapped by lack of VA medical records. Some records date back only a few years although the veteran has utilized the VA facility since WW II. Recently I discovered that there are medical records in storage at West Haven VA which would require a team of trained medical records personnel to review. This is not the fault of the present administration. Funds should be found to review these records in order that veterans can pursue their claim with the medical information they may need.

Thank you for the opportunity you have afforded me to bring these matters to your attention.

Sincerely,

Edward J. Giering
Commander, Connecticut Chapter
American Ex-Prisoners of War

PREPARED STATEMENT OF RICHARD J. PERRY, PRESIDENT CONCERNED VETERANS OF CONNECTICUT

Years ago a young fellow stood before the head of the VA on Cedar Street in New Haven, Connecticut, and was told "Your health care needs will always be taken care of by a grateful nation". I find that now, forty three (43) years later, the VA is not able to do this. Over the years, through some mismanagement by previous administrations, and a money crunch in Washington, the veteran is being let down.

The Hospital was run down badly, but even as I speak this is being turned around; the buildings are being remodeled, future new buildings are being considered, but we still have a long way to go to bring the Medical Center back to its rightful place in this world.

No one can deny that the Staff of the West Haven facility are the most dedicated loyal group of people I have ever encountered, but they are working under a terrible handicap, namely, out-dated equipment, staff shortages etc. We are losing more and more of our valuable employees to other hospitals and private industry, because the VA Medical Center can not compete salary wise in the job market. The money must be brought more competitive to entice the best there is into the facility.

Veterans in the "B" and "C" catagories are being put out of the hospital because they had been wise in planning their future. I am appalled at the idea that a mans status as a "Veteran" depends on how much money he has. As President of the "Concerned Veterans of Connecticut" I believe the Means Tests is a very unjust piece of legislature; fifteen thousand (15,000) dollars in the State of Connecticut is a drop in the bucket compared say to,the State of Mississippi. I believe the amount of money a veteran is allowed to make, should be judged by the cost of living in the state in which he lives. Also, we do not object to the insurance companies including Medicare, paying some of the tab, as long as the money goes to the veterans hospitals who supply the services, I repeat, the money goes to the hospital, not to a fund in Washington.

In closing, I would like to say the VA Medical Center needs more money so it can give the best medical services possible; as the saying goes "We are #1 because of our Veterans".

Let's not let Washington overlook this.

Thank you,
Richard J. Perry
RICHARD J. PERRY
President, Concerned
Veterans of Connecticut

TESTIMONY
OF
CONNECTICUT STATE COUNCIL
OF
VIETNAM VETERANS OF AMERICA
BEFORE
UNITED STATES HOUSE OF REPRESENTATIVES
VETERANS AFFAIRS COMMITTEE

PRESENTED BY
LINDA S. SCHWARTZ RN. MSN
SECRETARY VVA CHAPTER 270
MAY 15, 1989
NEW HAVEN, CONNECTICUT

Mr. Chairman the Connecticut State Council of the Vietnam Veterans of America appreciates this opportunity to present our views on the important subject of the retention and recruitment of health care professionals in the VA system. We are very aware that the care veterans receive is dependant on the quality, experience and competence of the professional and ancillary staff of our VA facilities. They are the very heart and soul of the system.

In considering the problems associated with retention and recruitment of professionals, we cannot overlook the many steps this committee has taken to respond to the problem. Despite these efforts to increase salaries and improve educational opportunities, the problems seem to continue to be unresolved. We are aware that presently there are shortages in physician, nursing, physical therapy and radiology technician positions.

In the past the VA was a leader in setting the standards for salaries, benefits and professional development opportunities for staff. Medical, Nursing and Technical schools and universities sought affiliations with VA facilities to broaden and enrich the educational experiences of their students. Researchers and Academicians prized their association with VA projects. However as we are all painfully aware, budgetary constraints, increasing patient care demands and competition in the private sector have eroded that leadership role.

No where is that more evident than the present difficulties with staffing of nursing personnel positions. The recent report by the Secretary of Health and Human Services Commission on the Nursing Shortage found that the VA was experiencing deficiencies in Registered Nurse positions before the nationwide shortage occurred. The Commission's Report also included recommendations about the VA's situation which are not only applicable to nursing but encompass the larger system issues which are relevant to the entire question of the recruitment and retention of all health care professionals.

Chief among the findings was the consideration of compensation. While there is a range of salaries and career steps within the Civil Service pay system, salaries at entry level positions are lower than in the private sector for many professional positions. In order to recruit into the system these entry level salaries must be at least equal to the pay offered in other facilities. The current competitive nature of the private sector in vying for professional staff, has created a situation in which the present Department of Veterans Affairs system for setting salaries is too time consuming and encumbered. It seems prudent to explore methods which would allow more flexibility at the local level in determining salaries so that VA facilities could be on an equal footing with other health care providers in their community.

As you are aware in order to finance these pay increases for nurses, physicians and other health personnel, VA medical centers have had to reprogram monies earmarked for other needs including equipment purchases, maintenance and supplies. We ask the Committee to consider measures which would give the VA more latitude within the annual budget to respond to these needs for salary increases. We are most concerned that this shuffling of funds may compromise other programs and aspects of care for the veteran. The VA medical care program cannot continue to absorb the costs of pay raises and special pay . Congress must make provisions for competitive pay and benefits for professional staff separate from the operating budget constraints.

The controlled growth imposed by the Federal Budget structure places additional burdens on professional staff that are not experienced in other health care settings. Because the ceiling on spending is fixed, vacancies in positions have not been filled. This has created a climate in which nursing personnel must absorb tasks normally carried out by other clinical and non-clinical staff. It is interesting to note that in the present DHHS Nursing Shortage Report, as in a 1984 VA study, the chief complaints of VA nurses remained inadequate staffing, lack of support services and stressful workloads.

The problems of inadequate staffing are reported nation wide. These have taken the form of reductions in staff, freezes in employment of Registered Nurses and Licensed Practical Nurses and Licensed Vocational Nurses and down substitutions. None of these situations are conducive to recruiting or retaining professional staff. We are aware that in Pennsylvania the problem with staffing was so troubling to the nurses that they took it upon themselves to organize and finance "Recruitment Teas" to help fill vacant positions.

We have also learned of instances in the work place in which even the most basic supplies needed to care for patients is unavailable to staff. Physicians and Nurses report that there is a scarcity of such items as hypodermic needles, lubricants, soap and dressings. There are cases in which even the most generic medications such as Lasix is unavailable. Patients have been readmitted to facilities because of adverse effects due to lack of appropriate medications. The Washington Post April 17,1989 carried a letter to Ann Landers which illustrates the dedication of VA staff and some of the difficult conditions in which they are asked to provide care. (Attachment 1)

Inadequate staffing has also meant that nurses are being substituted on specialized units such as the emergency room and oncology without an orientation. Reducing support personnel such as clerical, pharmacy and respiratory positions also increases the stress of the work place because it limits the capacity of professional staff to provide care and increases the workload. In this time of constraints, professional staff has been asked to do more with less and still derive a sense of satisfaction with the care they provide.

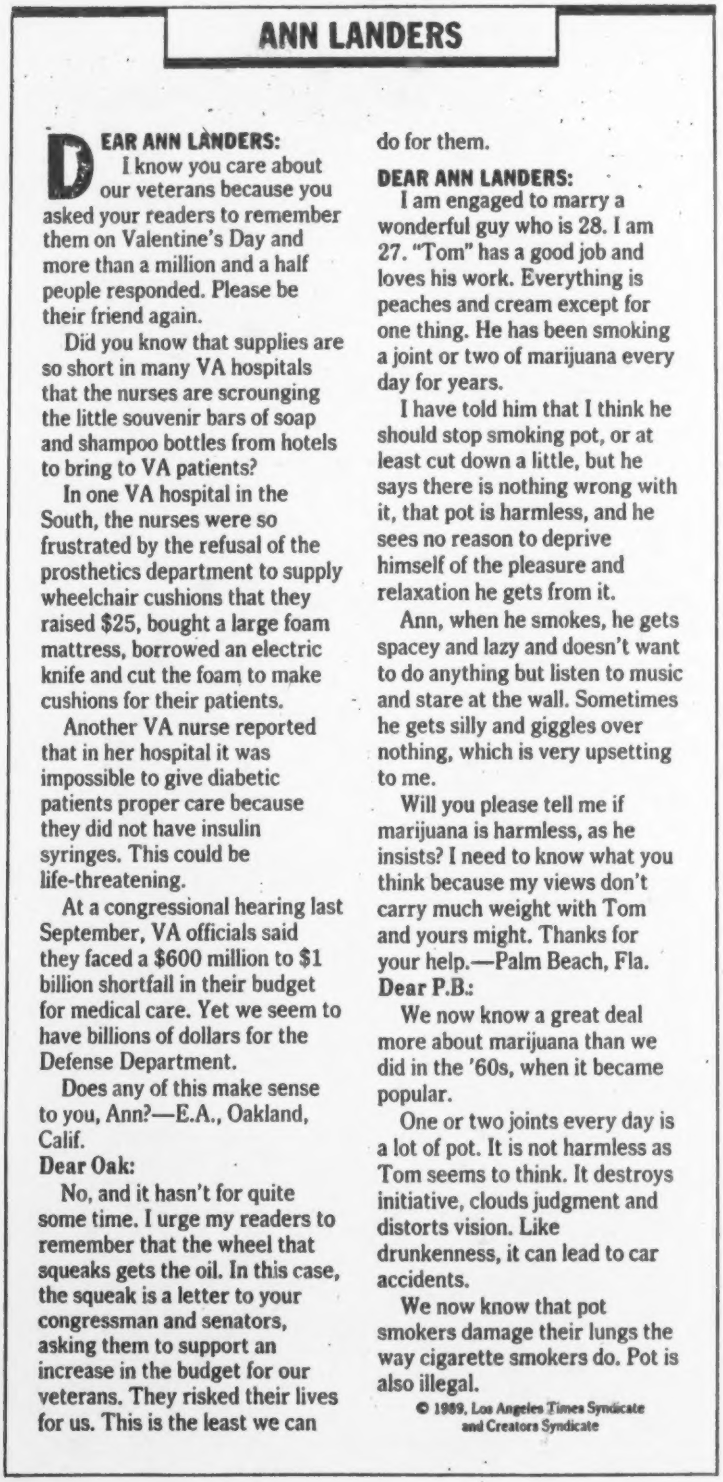
Vietnam Veterans of America believes that the VA's ability to provide quality care to veterans is seriously compromised by it's inability to compete with private sector recruitment and retention programs. We urge the Committee to consider the most important and logical first step to solving this problem is improving conditions in the work place. Such elementary steps as providing patient care and diagnostic supplies will give professionals the tools they need to provide quality care.

We know that medical and nursing schools have terminated affiliations with the VA because of the poor work environment. Student affiliations are an important aspect to VA recruitment. If schools are reluctant to send students to a facility, what incentive is there for graduates to explore employment opportunities in that system ? Salaries, benefits and professional educational opportunities must be competitive on the local level for any program of recruitment and retention to be effective.

The current crisis in the cost of health care in our country has created a climate in which larger numbers of veterans will have to turn to the VA for care. Increased severity in illness of those seeking care will require adequate professional staffing and patient care resources. VVA believes that recruitment and retention of health care professional in only one aspect of an even larger question of the quality of care for veterans. It is time to stop this pervasive game of robing Peter to pay Paul.

Current efforts to contain costs in the private sector provide valuable lessons that could be applied to the DVA as well. We believe that it is an opportune time to assess the real status of the largest health care system in the nation, to seek the most cost effective methods of care and to implement corrective measures which will ensure quality health care for veterans--now and in the future. We believe that there are numerous opportunities for this system to better serve the men and women who served this nation.

(From the Washington Post, April 17, 1989)



ANN LANDERS

DEAR ANN LANDERS: I know you care about our veterans because you asked your readers to remember them on Valentine's Day and more than a million and a half people responded. Please be their friend again.

Did you know that supplies are so short in many VA hospitals that the nurses are scrounging the little souvenir bars of soap and shampoo bottles from hotels to bring to VA patients?

In one VA hospital in the South, the nurses were so frustrated by the refusal of the prosthetics department to supply wheelchair cushions that they raised $25, bought a large foam mattress, borrowed an electric knife and cut the foam to make cushions for their patients.

Another VA nurse reported that in her hospital it was impossible to give diabetic patients proper care because they did not have insulin syringes. This could be life-threatening.

At a congressional hearing last September, VA officials said they faced a $600 million to $1 billion shortfall in their budget for medical care. Yet we seem to have billions of dollars for the Defense Department.

Does any of this make sense to you, Ann?—E.A., Oakland, Calif.

Dear Oak:

No, and it hasn't for quite some time. I urge my readers to remember that the wheel that squeaks gets the oil. In this case, the squeak is a letter to your congressman and senators, asking them to support an increase in the budget for our veterans. They risked their lives for us. This is the least we can do for them.

DEAR ANN LANDERS:

I am engaged to marry a wonderful guy who is 28. I am 27. "Tom" has a good job and loves his work. Everything is peaches and cream except for one thing. He has been smoking a joint or two of marijuana every day for years.

I have told him that I think he should stop smoking pot, or at least cut down a little, but he says there is nothing wrong with it, that pot is harmless, and he sees no reason to deprive himself of the pleasure and relaxation he gets from it.

Ann, when he smokes, he gets spacey and lazy and doesn't want to do anything but listen to music and stare at the wall. Sometimes he gets silly and giggles over nothing, which is very upsetting to me.

Will you please tell me if marijuana is harmless, as he insists? I need to know what you think because my views don't carry much weight with Tom and yours might. Thanks for your help.—Palm Beach, Fla.

Dear P.B.:

We now know a great deal more about marijuana than we did in the '60s, when it became popular.

One or two joints every day is a lot of pot. It is not harmless as Tom seems to think. It destroys initiative, clouds judgment and distorts vision. Like drunkenness, it can lead to car accidents.

We now know that pot smokers damage their lungs the way cigarette smokers do. Pot is also illegal.

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STATEMENT OF
WILLIAM J. STOCKELL
NATIONAL SERVICE OFFICER
DISABLED AMERICAN VETERANS
HARTFORD, CT
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
MAY 15, 1989

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than 15,000 members of the Disabled American Veterans and its' Ladies Auxiliary in the Department of Connecticut, I am pleased to have the opportunity to appear here today and present our views on the effects of the budget constraints to the quality and quantity of health care previously provided in the CT Department of Veterans Affairs Medical Centers as well as the Nation.

Mr. Chairman, I am quite familiar with the matter in question based on my job experience with the Disabled American Veterans Organization as a National Service Officer for the past 19 years. As a matter of fact, I personally spent five months in this facility in 1969 and 1970 for treatment of wounds sustained during combat action in the Republic of Vietnam. Over the years, our office in Hartford has been counseling and representing veterans in their need for medical treatment and compensations for disabilities that were incurred or aggravated during active military duty.

We recently received a newsletter from Congresswoman Nancy Johnson who is a former member of your distinguished House Committee of Veterans Affairs. In this February 1989 issue of Report to Veterans, the headline offers **"VETERANS HEALTH CARE AT A CROSSROADS."** For the sake of brevity, I am attaching a copy for the Committee's perusal. We feel she has hit the nail on the head. You have listened to testimony today supporting the fact that the budget constraints have affected not only the quantity but even more so the quality of health care being provided to the Nation's veterans. One of the slogans of the DVA health care system "treatment second to none" which appears on the walls of the DVAMC's throughout the country unfortunately may not be a valid statement. What is the cause of this decline? You have the Department of Veterans Affairs pointing the finger at Congress and Congress pointing the finger at the Office of Management and Budget. But, unfortunately, we are not doing anything to solve the problem.

We firmly believe that it may be time for Congress, through this Committee, to evaluate what should be the true mission of the DVA Health Care System. Then, you can proceed to properly fund that purpose. The needs of the veteran health care community have been changing and posing new needs based on the aging veteran population. We are looking at the drastic changes being employed by our two DVAMC's here in CT along which are creating new problems rather than solving existing ones. With the elimination of surgical procedures at the Newington DVAMC effective July 1 and the closing of several outpatient clinics at both facilities, we are looking at a new mode of DVA medical health care called "bussing"; and, as bussing added additional problems in trying to integrate the nation's school system, I am afraid bussing is going to add additional problems in trying to provide quality health care for the veteran population.

An example is said to be worth a thousand words; patients in need of chemotherapy at the West Haven DVA Medical Center are being bussed to the Bronx for their treatment which takes approximately 1 1/2 to 2 hours depending on traffic **each way**. The symptoms following chemotherapy in some patients may include nausea, vomiting and other side effects. The question that arises is, what provisions would be implemented for emergency medical treatment on the road? Will the drivers be qualified EMTs? We are looking at the possibility of additional claims being filed against the DVA with 38 USC 351 or through the Federal Court System as a tort claim, not to exclude the possibility of additional expenses to the medical center for emergency hospitalization at a private facility en route. As you can see, this is a variable can of worms.

The next question that arises is, how can this new mode of treatment be cost efficient from the standpoint of having to purchase vehicles, paying for upkeep of these vehicles and providing drivers. We already know that it is going to adversely affect the quality of care that veterans have been used to, and also cause extreme hardship in some cases.

In closing, it is our organization's belief that there is a most urgent need for supplemental funds so that the current quality of care can be kept at a level that we all believe our veterans have earned. You might also consider the possibility of setting a increased scale of salaries for physicians, clinicians and technicians in the New York, Boston and Connecticut areas because of the high cost of living and the competition of the private sector in being able to provide much high salaries and better benefit packages. For the long term, we are asking the Committee's indulgence of reassessing the current mission of the DVA Medical Health Care Delivery System, and then provide the necessary funding for its operation.

6th District, Connecticut

Congresswoman
Nancy Johnson

119 Cannon H.O.B. Washington, D.C. 20515
(202) 225-4476
1 Grove Street New Britain CT 06053
(203) 223-8412

February, 1989

DIRECTOR TDY
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ACTION
INFO DC's & [illegible]
DISCUSS WITH
SUSPENSE
FILE

REPORT TO VETERANS

VETERANS HEALTH CARE AT A CROSSROADS

The President's choice to be the nation's first cabinet-level Secretary of Veterans Affairs, Edward Derwinski, has already defined his number-one task as "maintaining the quality of health care" at veterans facilities.

In Connecticut, we face challenges in veterans health care which, though they differ somewhat from those at the national level, are no less serious. While VA centers in other parts of the country are serving more veterans than ever before, usage rates have continued to fall in Connecticut, threatening the already-tight budgets of our two VA hospitals.

There have been rumors lately that services will be cut, veterans turned away, and even that Newington hospital may be closed. This is not the case, and I wanted to share with you the facts on the VA hospital system's situation in the hopes that we may work together to ensure quality health care for veterans.

AGING PATIENTS AND AGING FACILITIES

The crisis in veterans health care is not simply a question of money but on what that money is spent. While federal spending on veterans health care has doubled since 1980, money spent on capital improvements needed to handle modern equipment and treatments has lagged. This is evident at both Newington, which was originally built in the 1930s, and West Haven, built in the 1950s.

For instance, West Haven administrators learned last year that the hospital was unable to perform angioplastic surgery, used on patients with blocked arteries, even though the hospital had invested thousands of dollars in equipment. The reason: West Haven's operating rooms were too poorly ventilated to allow open-heart surgery, which angioplasty patients might need. Newington, meanwhile, would require millions of dollars in improvements simply to meet safety and fire codes.

As a former member of the House Veterans Affairs Committee, I have worked with the committee as well as other members of the Connecticut delegation to ensure that both our VA hospitals will not only remain open, but also be able to correct deficiencies which prevent them from delivering modern, top-notch care. As a first step, the VA has included in its new budget $58 million for new construction and improvements to the Newington hospital.

The second challenge that must be addressed is how veterans' changing demand for care will be met. As more veterans choose to use private care providers and insurance, Newington and West Haven have both seen a decline in overall patient usage. And, as the veterans population ages, the demand for specialized geriatric-related care continues to grow.

Declining usage of specific services is a particular problem for Newington as the hospital must justify the care it offers as part of the national VA health care system. The drop in demand has been dramatic: Five years ago, the hospital handled 1350 surgical inpatient cases; last year, it treated just over half that amount.

One serious side effect of the precipitous drop in demand for Newington's surgical care is that the hospital has lost its important relationship with

Congresswoman
Nancy Johnson
Special Report

FEB 27 9 37

Congress of the United States
House of Representatives
Washington, D.C. 20515
OFFICIAL BUSINESS

Nancy L. Johnson M.C.

Mr. Robert Schloendorn, Dir.
VA Regional Office
450 Main Street
Hartford, CT 06103

UConn. The University has been forced to discontinue its surgical residency training program at Newington because the hospital's surgical caseload has become too small to meet national certification standards for a teaching program.

NEWINGTON AND WEST HAVEN: WORKING TOGETHER TO SERVE ALL VETERANS

As a result, administrators of both hospitals have been working together to create a plan under which they can cooperate to provide better care for all Connecticut veterans. Under the plan, specialized care offered by the two centers would be improved by consolidating resources and eliminating duplication of services. The plan would allow the two hospitals together to offer better care than each could provide separately.

Specializing the hospitals functions would not affect ambulatory and emergency care, those most commonly used by veterans. In fact, hospital administrators have vowed to further improve those services. Specializing will, however, allow the hospitals to strenthen their ability to provide the most modern treatments.

The plan calls for Newington to become a center for geriatric and longer-term care for veterans, while West Haven would strengthen its role as an acute care center. Connecticut badly needs a facility which provides better geriatric programs; currently, some types of care are not even available. For example, Connecticut veterans who are ventilator-dependent must now seek care at a private facility in Massachusetts at a cost of $800 per day. Even veterans in need of simple nursing home care must now wait months to be admitted to private homes.

It is important that we make costly and critical types of care like this more readily accessible to our veterans, and the proposal to expand geriatric care services and increase the number of intermediate care beds at Newington will accomplish that.

It would also allow the hospital to enter into a new relationship with UConn, which has been endowed by the Travellers, Inc. to do geriatric research. Neglected areas such as Alzheimer's research would benefit, and veterans afflicted with this and other conditions more common to older Americans could count on better access to first-class care.

WILL VETERANS BE TURNED AWAY?

Meanwhile, veterans seeking other types of care would still receive it. Veterans needing ambulatory care would still be cared for at a new and expanded Newington facility, and those admitted to Newington requiring surgery could either be rushed to New Britain General for emergency attention or transported to West Haven for elective or other types of surgery. Veterans will still be treated, and in fact can look forward to better care for many specific problems.

For this plan to succeed, veterans need to be well informed on the changes they can expect at Newington and West Haven. I would be happy to meet with veterans groups to learn your concerns and share what I know about this issue. If you would like me to meet with your veterans group, please have your post commander or secretary contact my office in New Britain at (203) 223-8412.

STATEMENT OF RICHARD J. HENNESSEY, COMMANDER, DEPARTMENT OF CONNECTICUT, DISABLED AMERICAN VETERANS AT WEST HAVEN, CONNECTICUT

BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE OF THE COMMITTEE ON VETERANS AFFAIRS, U. S. HOUSE OF REPRESENTATIVES

MAY 15, 1989

Mr. Chairman and Members of the Committee,

The Disabled American Veterans, Department of Connecticut, appreciates the opportunity to present its views by appearing before your committee on a most urgent matter, which we have been attempting to resolve for the past two decades, but to no avail.

For the sake of brevity, attached is a Press Release and copy of a letter to the President of the United States by our beloved former Member of Congress and Governor of the State of Connecticut, the late Ella Grasso. Ironically, this press release was issued 15 years to this very day. The problem of health care needs for veterans in the State of Connecticut was acute then, and it is more so today with the devastating deterioration of both VA medical centers in West Haven and Newington, CT.

Cognizant that this subcommittee is primarily concerned in learning of problems with recruitment and retention of health care professionals, as indicated by your distinguished chairman, Mr. Montgomery, we wish to emphasize that the archaic physical plant conditions have presented unsurmountable problems to the two VA medical centers here in Connecticut.

We are indeed familiar and sympathize with the existing budgetary constraints; the inalienable fact of the matter remains that new facilities have been projected for two decades; and the veterans of Connecticut have been victimized by diversonary funding procedures, which created the existing fiasco in plant and equipment in both medical centers.

The Disabled American Veterans, Department of Connecticut, would welcome an opportunity to participate in an indepth and nonpartisan sanctioned survey of VA health care delivery services in Connecticut. The situation as reported by then Congresswoman Ella Grasso and the DAV has deteriorated from that reported 15 years ago and needs to be updated as there is no apparent relief in sight.

Unless immediate action is taken by this committee, we fear that Connecticut again may be shortchanged and implore bipartisan support to deliver and favorably ensure adequate resources for the veterans' health needs in Connecticut and Western Massachusetts.

Mr. Chairman, that concludes my statement. At this time I would like to yield to my colleagues in our National Service Office in Hartford, Messrs. Stockell and Collin in the event they might wish to comment on this most important topic.

Once again, we thank the subcommittee for the opportunity to present our views.

Enclosure.

From the office of
U.S. Representative **Ella T. Grasso** of Connecticut

431 Cannon House Office Building, Washington, D.C. 20515 • Tel.: 202–225-4476

NOT PRINTED AT GOVERNMENT EXPENSE

FOR RELEASE: WEDNESDAY, MAY 15, 1974

WASHINGTON, D.C.--U.S. Representative Ella Grasso (D-6th District) Tuesday asked President Nixon to recommend the construction of a new Veterans Administration hospital at the University of Connecticut Medical Center site in Farmington, and the renovation of the existing VA hospital in Newington for use as an extended care facility.

"Only in this way can we ensure that Connecticut veterans get the top-flight health care they deserve," Mrs. Grasso, a member of the House Veterans' Affairs Committee, told the President in a letter mailed Tuesday.

In her letter Mrs. Grasso asked the President to initiate studies and surveys immediately to prepare for the inclusion of funds for the new VA hospital and for needed renovations at Newington in the VA budget which will be submitted to Congress next January.

Mrs. Grasso cited specific health needs of veterans in Connecticut that would be met by the improvements in care she is urging. She said that the new Farmington hospital should include an extensive psychiatric unit with an alcoholism treatment program. After the hospital is built, a renovated Newington facility would fill a need for nursing home care, which is increasing as World War I and II era veterans grow older.

In presenting a case for improved VA health care in Connecticut, Mrs. Grasso used information and ideas from testimony taken at an August hearing in New Britain of the Veterans' Affairs Committee's Hospitals Subcommittee, which was chaired by Mrs. Grasso, a member of the Subcommittee. She called the hearing to determine the level and quality of health care available to Connecticut veterans. VA hospital administrators, representatives of veterans organizations and others testified.

"What emerges from the testimony is the picture of conscientious hospital administrators and shorthanded hospital staffs attempting to do well by our veterans in facilities inadequate to meet the needs of Connecticut's large veteran population," Mrs. Grasso reported.

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The evidence Mrs. Grasso presented to the President support the need for VA health care improvements includes the following.

****Connecticut has one VA surgical or general medical bed per 614 veterans in the state as compared with a national average of one per 449 veterans;

****Trends indicate that admissions at the existing hospitals are rising. West Haven registered a rise of 24,000 patient days in the two year period from 1971-73. At Newington, total admissions for 1973 were 501 patients above the 1971 level;

****There are only 129 VA beds in the state for psychiatric treatment. As a result, 40 percent of the patient load at the Northampton, Massachusetts VA hospital consist of Connecticut veterans there for psychiatric or nursing care;

****Ongoing psychiatric care is particularly important now with the special adjustment problems of some of Connecticut's 100,000 Vietnam veterans;

****Over 60 percent of Connecticut's 462,000 veterans are from the World War I and II eras, and are becoming more susceptible to chronic illness as they grow older; yet only 90 beds are available for veqterans nursing care in the state. That represents one nursing care bed for every 2,711 World War I and II veterans in the state.

Mrs. Grasso noted that the idea for building a new VA hospital at the Farmington site dates back to 1966 and 1967. This location would "provide the opportunity for a valuable affiliation and effective medical partnership between the medical staffs of the University facilities and the VA hospital," she said.

The complete text of Mrs. Grasso's letter to the President follows.

May 14, 1974

The President
The White House
Washington, D.C.

Dear Mr. President:

The contributions of veterans in Connecticut and throughout the nation to the defense and security of our country make them truly special men and women.

Certainly one way in which we honor these deserving Americans is through benefits made available to them by the Veterans Administration, including medical and health care in VA hospitals. I am sure you will agree that a primary objective of the VA is the efficient delivery of top-flight health care for veterans.

As a member of the House Veterans' Affairs Committee, it has been my privilege to work with the VA and with veterans' organizations on a state and national level to ensure needed services to our veterans. Last August I chaired a hearing of our committee's Hospitals Subcommittee in New Britain, Connecticut, with the aim of determining the level of health care available to veterans in our state. Among those who testified were representatives of the VA and of Connecticut's veterans' organizations.

In short, our hearing was extremely informative. What emerges from the testimony is the picture of conscientious hospital administrators and shorthanded hospital staffs attempting to do well by our veterans in facilities inadequate to meet the needs of Connecticut's large veteran population.

Veterans in Connecticut at the present time total 462,000. The VA has two hospitals in our state, one in Newington, and the other in West Haven. The Newington hospital is pre-World War II vintage--quite an old building--while the West Haven facility opened in 1953.

Together these hospitals have a total of 752 hospital beds for general medical and surgical patients. This excludes specialized wards such as those for psychiatric patients, blind rehabilitation, kidney dialysis, and nursing home care. Based on these statistics the VA in Connecticut provides a bed for every 614 of our state's veterans. This does not compare favorably with the national average of one bed for every 449 veterans.

Trends at the two hospitals point up an increase in the use of the facilities by veterans. Statistics presented at the hearing in New Britain show that admissions at Newington rose from 2,728 in 1971 to 3,059 in 1972. That figure for fiscal year 1973 was 3,229. Admissions for this fiscal year were 2,910 at the end of April, and it is expected that the final figure for this year will be larger than last year's total.

At the West Haven hospital the average daily census in 1971 was 552 patients, while for 1973 it increased to 638. This represents a rise of 24,090 patient days in the two-year period.

While statistics on daily patient census and admissions can help to represent the general situations at hospitals, these cannot fully illuminate the problem of veterans health care in Connecticut. Indeed, there are certain specific areas where health care is inadequate and where services must be improved.

-more-

Certainly, one of those areas in Connecticut is the psychiatric care available to our veterans. Between the two hospitals, beds for in-patient psychiatric treatment number only 129. As a result, veterans in Connecticut who require in-patient psychiatric treatment often must be admitted to out-of-state VA hospitals, such as the one in Northampton, Massachusetts. Indeed, one hospital administrator, in testimony before the Hospitals Subcommittee, indicated that 40 percent of the patients at the Northampton hospital are Connecticut veterans receiving either psychiatric of nursing home care. With psychiatric patients, especially, an important element of treatment is the love and care that a patient's family and friends can provide through regular visits. Needless to say, such visits are difficult when one must travel many miles to be with a loved one who is hospitalized.

In addition, adequate ongoing psychiatric care for our veterans is of particular importance at this time due to the special adjustment problems of some of Connecticut's 100,000 Vietnam veterans.

In connection with the need for more in-patient psychiatric care for veterans in Connecticut, our hearings showed there is also a lack of adequate VA programs and facilities for the treatment of alcoholism. There is no alcoholism treatment unit in either of the VA hospitals at this time, though an encompassing alcoholism program is badly needed.

Another area in which an improvement in VA health care delivery must be made in Connecticut is in the nursing home care available to our veterans. We know that people become more susceptible to chronic illness as they grow older. Over 50 percent of Connecticut's veterans belong to the World War I and II generations. It is clear, then, that now and especially in the years ahead, an increasing need for longterm nursing home care must be met. Yet, of the two VA facilities, only one--West Haven--has provisions for nursing home care, though available beds total only 90. This represents one bed for every 2,711 World War I and II era veterans in the state.

We are indebted to the service officers and other representatives of the Connecticut Veterans' organizations who have continually provided information on health care for veterans in our state. Their firsthand experience is extensive. Their accounts portray hospitals with shorthanded staffs--sometimes at a level so deficient as to be dangerous. They also describe buildings at Newington that are too outmoded to accommodate the equipment required for modern medical techniques.

Clearly, constructive change is essential in VA facilities in my state--change that must be initiated immediately.

For this reason, I request that you initiate studies and surveys immediately in preparation for including funds for the construction of a new VA hospital in Connecticut in the VA budget to be submitted to Congress in January. The new hospital would be built at the site of the University of Connecticut Medical Center in Farmington. The location of this facility on the Medical Center site would provide the opportunity for a valuable affiliation and effective medical partnership between the medical staffs of the University facilities and the VA hospital. In testimony before the Hospitals Subcommitte, Dr. Robert U. Massey, dean of the University of Connecticut Medical School, joined representatives of the veterans' organizations in urging that action on a new VA hospital in Farmington begin soon.

The new hospital must be fully equipped and staffed to provide a high level of health and medical care for Connecticut veterans. It is our hope that an extensive psychiatric treatment facility will be provided, including in-and-out-patient programs for alcoholism treatment and care.

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The idea of [illegible] is not a new one. Indeed, a conference on a new Connecticut hospital was held in 1966 in the office of Representative Olin E. Teague, then chairman of the House Veterans' Affairs Committee. Attending that conference were representatives of Connecticut veterans' organizations, Representative Emilio Daddario, formerly Congressman from Connecticut's First District, staff members of the Veterans' Affairs Committee, together with then VA Administrator William J. Driver and his staff. A year later, at a conference in Connecticut, Mr. Driver assured veterans' representatives, Representative Daddario and deans of the University of Connecticut Medical and Dental Schools that the hospital at Newington and all World War II vintage hospitals would be replaced.

Mr. President, I want to take this opportunity to make a second major recommendation. It is my belief that after the new VA hospital is built in Farmington, the Newington hospital should be renovated to make it suitable as a facility for so-called extended or nursing home care, which is vitally needed by Connecticut veterans. The Newington facility, with its beautiful grounds, is ideal for this purpose. I, therefore, respectfully request that a study now be undertaken in preparation for including in the next VA budget funds for the renovation needed at Newington.

Only in this way can we assure that Connecticut's veterans get the top-flight health care they deserve. These recommendations and the changes they embrace are essential if the federal government is to show its commitment to caring for these valiant men and women who have given so much for their country.

I hope that my recommendations will receive prompt and favorable consideration.

With best wishes,

Cordially,

/s/ Ella Grasso

ELLA GRASSO
Member of Congress

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DISABLED AMERICAN VETERANS

(Chartered by Act of Congress)
CHARLES K. MERRITT CHAPTER No. 20, INC.
Stratford, Nichols & Monroe Conn.

May 10, 1989

TO: The Honorable Bruce Morrison, Congressman

FROM: Joseph R. Bruno, Commander, Chapter 20, Stratford, Ct.

SUBJECT: REMOVAL OF CATEGORY A,B,C AND MEMORIAL DAY

On Monday, May 29, 1989 our Country will be celebrating Memorial Day to honor a special group of American heroes. This day has been set aside by our Nation to remember those who died in our wars. Traditionally, on this day, thousands of graves will be marked with small American Flags, a symbol of spirit and courage for the men who sacrificed their lives for freedom.

Freedom - Liberty - Independence .....These were never just empty phrases to our soldiers. These were ideals to live for and, if necessary, to die for. As we pay tribute to these American heroes on Memorial Day, we must never forget the ultimate price they paid for freedom.....not just for their freedom, but freedom for all.

On January 1, 1989 the Department of Veterans Affairs implemented a cost of living adjustment for veterans who must meet certain income requirements to obtain medical care. These limits apply to veterans who are not service connected. It is ironic how simple it is to forget the sacrifices of all our veterans, whether they be disabled or not. It would seem to me that the Congress of the United States of America, which symbolizes freedom, liberty and independence, would stoop to categorize with the simplicity of A,B,C.

I urge you to restore the dignity, so well deserved, to all our veterans and remove the stigma of not caring.

Joseph R. Bruno

STATEMENT OF WILLIAM J. POMFRET
COMMANDER
DEPARTMENT OF CONNECTICUT
THE AMERICAN LEGION

Congressman Morrison-Congressman Rowland, The American Legion, Department of Connecticut, appreciates the opportunity to present its views about the medical needs of Connecticut veterans before this Committee.

Many of the problems that face veterans today are not new problems--they have been around for the past 8 to 10 years. We do not seem to overcome any problems but we do have a way of being able to add to our problems.

The American Legion would like to point out the 3 major needs, or problems, that face Connecticut veterans today when they seek medical care in the 2 VA medical centers in Connecticut.

1. The inability of our medical centers to hire competent, qualified staff personnel to provide service and treatment to veterans.

Because Connecticut has the highest income per capita in the Nation, the setting of wage scales on a national basis may eliminate a hiring problem for many areas in the country-but it hampers the ability of the Connecticut VA medical centers to attract and pay for a quality staff, both professional and non-professional. Who suffers-the veterans of this State! The American Legion feels very strongly that the VA wage schedule should be established according to the economic conditions of the several areas of the nation. Regional wage structures are necessary if the VA medical centers in Connecticut are going to be able to compete in a labor market that is so highly competitive.

2. Another major concern of The American Legion is the lack of nursing home, or long-term care facilities. Fifteen years ago, The Legion completed a study on the future needs of Connecticut veterans. It was found that the number one problem was the care of the aging veteran. The need for facilities to provide long-term care was paramount. Believe it or not-the need for sufficient facilities to provide long-term care for the aging veteran is still our number one problem. Even though we knew 15 years ago that long=term care would be required by the biggest pool of veterans-the World War II veterans-little or nothing has been done to prepare for this need. Recently, I was in Washington and listened to the very ambitious plans of the VA to build a number of new medical centers. This is fine, however, perhaps a review of the spending should be made. Perhaps we should be looking into staffing the facilities we have and building the facilities for long-term care rather than invest money in projects that will be unable to help us overcome our present problem-caring for veterans today.

3. In addition, updating our present facilities and providing modern equipment must be addressed--otherwise second-rate care will be provided to our veterans. This should not happen. Finally, The American Legion strongly opposes the imposition of the means test and third-party payment regulation. Let's provide medical care to all our veterans as it should be. No one asked the veteran how much money he had when they asked him to serve his country.

Thank you very much for your attention and for all that you both have done for veterans of this country.

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